National Health Reform (NHR) — Medicaid Purchasing Administration (MPA) Project Planning

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NOTE: EFFECTIVE DATES HIGHLIGHTED IN DARK PINK IN THE MATRIX THAT FOLLOWS ARE THOSE THAT ARE NEAR-TERM.

	NHR PROVISION	EFFECTIVE DATE	LEAD SPONSOR(S)	LEAD MANAGER(S)	TYPE	*LEGISLATION NEEDED (date)	*FISCAL IMPACT (date)	*CRITICALITY (high, med, low)
I.	**RELATED TO LOW-INCOME POPULATIONS/PROGRAMS**							
	A. MEDICAID ELIGIBILITY							
	1. GENERAL							
	I-1. FINANCIAL ELIGIBILITY REQUIREMENTS FOR 'NEWLY ELIGIBLE' AND OTHER NON-ELDERLY POPULATIONS DETERMINED USING MODIFIED ADJUSTED GROSS INCOME (MAGI) [§§ 2001 AND 10201 OF H.R. 3590 (PPACA) AND §1004(A)(2) OF H.R. 4872 (HCERA)] Medicaid coverage is expanded to individuals with incomes under 133% FPL (with a 5% income disregard = 138% FPL) using MAGI, who are under 65 years of age, not pregnant, not eligible for Medicare Part A or Part B, and those not described in previous subclauses. Permits presumptive eligibility determinations for these individuals if previously allowed for children and pregnant women. ***Possible Action Needed & Status (date)*** ▪ Modify ACES (?), income determination methodologies, RCW, WAC, policies	**1/1/2014**	**Manning Pellanda**	**Mary Wood**	**P**			
	I-2. FINANCIAL ELIGIBILITY REQUIREMENTS FOR CERTAIN POPULATIONS ELIGIBLE UNDER PRIOR LAW [§§ 2001, 2002, AND 10201 OF PPACA] Certain groups are exempted from MAGI for income eligibility determination. Prior income counting rules will apply for those eligible based on (1) another federal/state program (e.g., foster care, SSI), (2) advanced age, (3) SSI-related, (4) MN, or (5) Medicare Savings Program. MAGI also will not affect Express Lane determinations for Medicaid/CHIP children, Medicare Part D low-income subsidies, or Medicaid LTC services. Those made ineligible on 1/1/2014 due to MAGI will remain eligible until 3/31/2014 or next eligibility redetermination date. Prohibited use of asset or resource tests for purposes of determining eligibility for Medicaid for certain eligibility categories. ***Possible Action Needed & Status (date)*** ▪ Maintain current eligibility determination methodologies for these groups.	**1/1/2014**	**Manning Pellanda**	**Mary Wood**	**P**			
✓	**I-3. MAINTENANCE OF MEDICAID INCOME ELIGIBILITY [§§ 2001 AND 102010 OF PPACA]**	**3/23/2010**	**Manning**	**Mary Wood**	**T**			

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	States must maintain their current Medicaid and CHIP eligibility standards, methodologies, and procedures for adult populations until December 31, 2013, after which the State Exchanges begin. States also must maintain their current eligibility standards, methodologies and procedures for children in Medicaid and in CHIP until September 30, 2019. MOE exception between 1/1/2011 and 12/31/2013 for nonpregnant, nondisabled adults whose income exceeds 133% FPL for states with certified budget deficits. Unlike ARRA, States lose *all* Medicaid FFP for Medicaid and CHIP MOE violation and not just additional FMAP. ***Possible Action Needed & Status (date)*** ▪ Remain cognizant of MOE requirements during budget reduction exercises.		**Pellanda**					
	I-4. MEDICAID COVERAGE FOR FORMER FOSTER CARE CHILDREN [§§ 2004 AND 10201 OF PPACA] Establishes Medicaid coverage (with EPSDT benefits) for children under age 26 who were in foster care when they turned 18. This group is exempt from mandatory enrollment in DRA benchmark plans. ***Possible Action Needed & Status (date)*** ▪ Collaborate with Children's Administration (CA) ▪ Modify ACES, RCW, WAC, and policies.	**1/1/2014**	**CA; MPA Support (MaryAnne Lindeblad; Manning Pellanda)**	**CA (Tammy Cordova); MPA Support (Todd Slettvet; Mary Wood)**	**P**			
	I-5. HEALTH CARE POWER OF ATTORNEY [§ 2955 OF PPACA] Mandatory transition plan for youth aging out of foster care (FC) must include (1) information about designating another individual to make health care treatment decisions on their behalf and (2) options for health insurance. ***Possible Action Needed & Status (date)*** ▪ Collaborate with CA to develop health care oversight plans required as part of the FC transition planning process.	**10/01/2010**	**CA; MPA Support (MaryAnne Lindeblad; Manning Pellanda)**	**CA (Tammy Cordova); MPA Support (Todd Slettvet; Mary Wood)**	**O**			
	I-6. PROTECTIONS FOR RECIPIENTS OF HOME- AND COMMUNITY-BASED SERVICES (HCBS) AGAINST SPOUSAL IMPOVERISHMENT [§ 2404 OF PPACA] Requires application of spousal impoverishment rules to (1) HCBS clients, (2) when determining MN eligibility for HCBS, and (3) applicants for the newly expanded HCBS	**1/1/2014** **for 5 years (through CY 2018)**	**ADSA**	ADSA	**O**			

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	state plan benefit under the DRA. ***Possible Action Needed & Status (date)*** ▪ Coordinate with Aging & Disability Services Administration (ADSA) as needed.							
	2. OPTIONAL ELIGIBILITY EXPANSION OPPORTUNITIES							
✓	**I-7. EARLY EXPANSION FOR PARENTS AND NON-ELDERLY, NON-PREGNANT INDIVIDUALS WITH FAMILY INCOME BELOW 133% OF THE FPL [§§ 2001 OF PPACA AND 1201 HCERA]** Effective April 1, 2010: SPA option for states to expand Medicaid to individuals with incomes under 133% (with a 5% income disregard = 138% FPL) who are under 65 years of age, not pregnant, not eligible for Medicare Part A or Part B, and those not described in previous subclauses. States may use MAGI for income determination or—until 1/1/2014—another approved methodology. Beginning 1/1/2014, services for these new eligibles will draw down increased FMAP; until that time, only regular (non-ARRA) FMAP will be available if the waiver is approved. ***Possible Action Needed & Status (date)*** ▪ Submit Basic Health (BH)/Medical Care Services (MCS) Bridge Funding request (§ 1115 Medicaid demonstration waiver).	**4/1/2010** **but 1/1/2011 is target date to apply federal funds toward BH and MCS coverage**	**Low-Income Workgroup (Roger Gantz)**	**Low-Income Workgroup (Jenny Hamilton)**	**P**			
	I-8. OPTIONAL EXPANSION FOR NON-ELDERLY, NON-PREGNANT INDIVIDUALS WITH FAMILY INCOME ABOVE 133% OF THE FPL [§§ 2001 AND 102010 OF PPACA] States may cover these people up to a maximum level specified in the Medicaid state plan (or waiver); income eligibility will be determined based on MAGI. Coverage can be phased-in based on income, as long as the state does not extend coverage to (1) individuals with higher income before those with lower income, or (2) parents unless their child is enrolled in the state plan, a waiver, or in other health coverage. States may rely on this state plan option to meet the MOE requirements. No increased ARRA FMAP for this new optional eligibility group. ***Possible Action Needed & Status (date)*** ▪ Decide by 2012 if this option is fiscally feasible.	**1/1/2014**	**Low-Income Workgroup (Roger Gantz)**	**Low-Income Workgroup (Jenny Hamilton)**	**A**			
	I-9. STATE ELIGIBILITY OPTION FOR FAMILY PLANNING SERVICES [§ 2303 OF PPACA] States may provide Medicaid coverage for family planning services through a State	**3/23/2010**	**MaryAnne**	**Maureen**	**T**			

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	Plan Amendment (SPA) to certain low-income individuals up to the highest level of eligibility for pregnant women (185% in WA; with income disregards for Family Planning, eligibility could be calculated down to this level). ***Possible Action Needed & Status (date)*** ▪ Decide whether to pursue this option or continue with waiver. ▪ If former, submit savings DP for 2011 (?) and SPA to CMS.		**Lindeblad**	**Considine**				
	I-10. REMOVAL OF BARRIERS TO PROVIDING HOME- AND COMMUNITY-BASED SERVICES [§ 2402 OF PPACA] Expands access to this benefit to persons with income up to 300% of the SSI benefit rate. In addition, it specifically allows persons who qualify for Medicaid HCBS waiver services because they require an institutional level-of-care, to qualify for this section 1915(i) state plan option, which permits states to offer these services to this population through a SPA rather than a waiver. Furthermore, the law established section 1915(i) as a new optional eligibility pathway into the program. Under the new law, states may also extend full Medicaid benefits, as well as this HCBS state plan benefit, to this new eligibility group. See Section I.B below for more detail. ***Possible Action Needed & Status (date)*** ▪ Support and coordinate with ADSA as needed.	**7/1/2010** **(1st day of the 1st FFY quarter that begins after the date of enactment)**	**ADSA; MPA Support (MaryAnne Lindeblad; Manning Pellanda)**	**ADSA; MPA Support (Gail Kreiger; Mary Wood)**	**O, T**			
	3. OUTREACH & ENROLLMENT FACILITATION							
	I-11. STREAMLINING PROCEDURES FOR ENROLLMENT THROUGH A HEALTH INSURANCE EXCHANGE AND MEDICAID, CHIP, AND OTHER HEALTH SUBSIDY PROGRAMS [§ 1413 OF PPACA] HHS to develop an application system which ensures that individuals eligible for Medicaid/CHIP who are applying for tax credits in the Exchange are enrolled in Medicaid/CHIP instead. ***Possible Action Needed & Status (date)*** ▪ Await Secretary development and distribution of a standard, streamlined application or develop one that is consistent with the Secretary's.	**1/1/2014**	**Manning Pellanda; Exchange Workgroup**	**Mary Wood**	**P**			
	I-12. ENROLLMENT SIMPLIFICATION AND COORDINATION WITH STATE HEALTH INSURANCE EXCHANGES [§ 2201 OF PPACA]	**1/1/2014**	**Manning Pellanda with**	**Mary Wood**	**P**			

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	To receive FFP for Medicaid, States must: **a.** Establish a process for online applications and renewals (including electronic signature) for Medicaid and to compare details of all available Medicaid plans, **b.** Accept Exchange eligibility determinations for Medicaid and CHIP, **c.** Ensure Medicaid/CHIP applicants deemed ineligible are screened for enrollment in Exchange plans and obtain premium assistance without another application, **d.** Ensure that Medicaid, CHIP, and Exchange use a secure electronic interface that allows enrollment in Medicaid, CHIP or a qualified plan, **e.** Ensure coordination of benefits (COB), including EPSDT, for Medicaid/CHIP enrollees also enrolled in Exchange plans, **f.** Conduct outreach and enrollment of vulnerable populations, **g.** Establish a website that links Medicaid to the Exchange. ***Possible Action Needed & Status (date)*** ▪ MPA DSM, DESD, and other divisions to coordinate with ESA and HCA.		**support from ESA; Exchange Workgroup**					
	I-13. STANDARD AND BEST PRACTICES TO IMPROVE ENROLLMENT OF VULNERABLE AND UNDERSERVED POPULATIONS [§ 2201 OF PPACA] Requires the Secretary to work with stakeholders to develop and issue guidance to states regarding standards and best practices to help improve enrollment of vulnerable populations in Medicaid and CHIP. ***Possible Action Needed & Status (date)*** ▪ Participate in stakeholder process as appropriate.	**4/1/2011**	**Manning Pellanda with support from ESA, dependent upon CMS guidance**	**Mary Wood**	**A, P**			
	I-14. NEW REPORTING REQUIREMENTS [§§ 2001 AND 10201 OF PPACA] Annual report on Medicaid enrollment, including the total number of enrolled and newly enrolled individuals broken out by eligibility categories and client populations, and a description of outreach activities. Additional enrollment and retention monitoring reports may also be required by the Secretary. ***Possible Action Needed & Status (date)*** ▪ Begin development of the required report or modifications of existing	**01/01/2015 and annually thereafter for the FFY ending Sept 30 of the preceding CY**	**Rich Campbell**	**Cathie Ott**	**P**			

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	report(s).							
	I-15. PERMITTING HOSPITALS TO MAKE PRESUMPTIVE ELIGIBILITY DETERMINATIONS FOR ALL MEDICAID POPULATIONS [§ 2202 OF PPACA]—<u>OPTIONAL</u> Allows states to permit all hospitals that participate in Medicaid to make presumptive eligibility determinations for all Medicaid eligible populations. ***Possible Action Needed & Status (date)*** ▪ Determine if it is feasible to enable hospitals to perform this function. ▪ Clarify whether this is truly optional—C&B #16 says that the hospital makes the choice "regardless of whether the State has elected to provide presumptive eligibility," but other sources indicate otherwise.	**1/1/2014**	**Manning Pellanda with support from ESA**	**Mary Wood**	**A**			
	B. MEDICAID BENEFITS							
	I-16. MEDICAID BENEFIT COVERAGE FOR THE NEW MANDATORY ELIGIBILITY GROUP [§§ 2001 AND 10201 OF PPACA] Provides all newly-eligible adults with a benchmark benefit package or benchmark-equivalent package. *Currently, DRA benchmark coverage must include items and services within each of the categories of basic services (inpatient and outpatient hospital, physicians' surgical and medical, laboratory and x-ray, well-baby and well-child care including immunizations, and other appropriate preventive services as determined by the Secretary). Family planning services were also added to benchmark coverage effective 3/23/2010.* Effective 1/1/2014, benchmark coverage must meet minimum essential health benefits available in the Exchange (including prescription drugs and mental health parity at actuarial equivalence to the benchmark). Populations exempt from mandatory enrollment in these benchmark plans (including the elderly, persons with disabilities, and pregnant women) remain exempt. States will not receive FFP for coverage of categories of benefits provided to new eligibles beyond benchmark coverage, except that any child enrolled as a new eligible must	**1/1/2011** **[upon implementation of a SPA/waiver for early expansion to the newly eligible population current DRA benchmark benefits (plus family planning) must be provided]**	**Low-Income Workgroup (Roger Gantz)**	**Low-Income Workgroup (Jenny Hamilton)**	**P**			

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	receive EPSDT services. ***Possible Action Needed & Status (date)*** ▪ Consider these requirements in development of the Basic Health and Medical Care Services waiver(s).							
	I-17. MODIFICATIONS TO DRA BENCHMARK AND BENCHMARK EQUIVALENT COVERAGE [§ 2001(C) OF PPACA] Expands on DRA benchmark coverage to include all the services required for the "essential health benefits package": ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services and devices, lab services, preventive and wellness services and chronic disease management, and pediatric services including oral and vision care. States will not receive FFP for coverage of categories of benefits provided to new eligibles beyond benchmark coverage, except that any child enrolled as a new eligible must receive EPSDT services. ***Possible Action Needed & Status (date)*** ▪ Consider these requirements in development of the Basic Health and Medical Care Services waiver(s), and before full expansion in 2014.	**1/1/2014** **except that family planning services were added to current DRA benchmark coverage upon enactment (3/23/2010)**	**Low-Income Workgroup (Roger Gantz)**	**Low-Income Workgroup (Jenny Hamilton)**	**A**			
	I-18. PREMIUM ASSISTANCE [§§ 2003 AND 10203(B)(2)(A) OF PPACA]—OPTIONAL Amends Section 1906A to permit states to offer premium assistance and wrap-around benefits to all Medicaid beneficiaries, when it is cost-effective to do so (there is a specific formula for determining this). Individuals are not required to enroll in employer-sponsored plans and can disenroll from coverage at any time. Section 1906A requires states to pay premium and cost sharing amounts that exceed the limits placed on premiums and nominal cost-sharing in Medicaid. ***Possible Action Needed & Status (date)*** ▪ Determine if there is interest in exploring whether it is cost effective to offer premium assistance to Medicaid clients.	**1/1/2014** **(the cost effective requirement is effective as if included in the enactment of CHIPRA: 2/4/2009)**	**Thuy Hua-Ly**	**Andy Renggli**	**A, T**			

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	I-19. BIRTHING CENTERS [§ 2301 OF PPACA]—MANDATORY Establishes care provided in free-standing birth centers as a mandatory Medicaid service. Free-standing birth centers are defined as health centers that are not hospitals, where childbirth is planned to occur away from the pregnant woman's residence, that are licensed or otherwise approved by the State to provide prenatal labor and delivery or postpartum care and other ambulatory services that are included in the plan, and that comply with any state-defined requirements relating to the health and safety of individuals. States must separately pay providers—including "birth attendants" regardless of whether they are operating under the supervision of a physician or other health care provider—administering prenatal, labor and delivery, or postpartum care in these centers. ***Possible Action Needed & Status (date)*** ▪ Determine if SPA or request legislation needed; SPA required, Mtg 9/23 @ 3 ▪ How are "birth attendants" defined? Are doulas included? NO (see C&B #21)	**3/23/2010** **unless state legislation is required (1st day of the 1st calendar quarter beginning after the close of the 1st legislative session beginning after ACA enactment, i.e., 7/1/2011)**	**MaryAnne Lindeblad**	**Jean Gowen**	**T**			
	I-20. SMOKING CESSATION SERVICES FOR PREGNANT WOMEN [§ 4107 OF PPACA] —MANDATORY Adds counseling and pharmacotherapy to promote cessation of tobacco use by pregnant women as a mandatory benefit and prohibits cost-sharing for these benefits. States will receive a one percentage point increase in their regular FMAP for these smoking cessation services for pregnant women if they elect to cover the new optional adult preventive care benefit described below. ***Possible Action Needed & Status (date)*** ▪ Already covered benefits for pregnant women, but via DOH (or MSS? Or both?), must ensure no cost-sharing in the future. Mtg for SPA 9/23/10.	**10/1/2010** **increased FMAP of 1% after 1/1/2013**	**MaryAnne Lindeblad**	**June Hershey, Ellen Silverman**	**T**			
	I-21. ADULT PREVENTIVE CARE [§ 4106 OF PPACA; SEE ALSO § 1001/2713]—OPTIONAL The state option for diagnostic, screening, preventive and rehabilitation services are expanded to include any clinical preventive services that are assigned a grade of A or B by the United States Preventive Services Task Force and adult vaccines recommended by the Advisory Committee on Immunization practices, and the administration of those adult vaccines. States that elect to cover these services, and that do not require cost-sharing for the services (which isn't permitted for the new	**1/1/2013**	**MaryAnne Lindeblad**	**Shirley Munkberg**	**A, P**			

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	eligibles), will receive a 1% FMAP increase (+ increased FMAP applicable to new eligibles or in addition to regular FMAP for former eligibles) for preventive services and for the tobacco cessation services described in Sec. 4107. New group and individual health plans are <u>required</u> to provide these preventive services and may not apply cost-sharing to them (all plans must satisfy these requirements by 2018). Could be applicable to Medicaid managed care plans (?). ***Possible Action Needed & Status (date)*** ▪ Determine if MPA or its Healthy Options (HO) plans already do or wish to offer these optional services. Must ensure no cost-sharing for them.							
	I-22. SCOPE OF COVERAGE FOR CHILDREN RECEIVING HOSPICE CARE [§ 2302 OF PPACA]—<u>MANDATORY IF OPT TO COVER HOSPICE</u> At a state's option, Medicaid and CHIP child beneficiaries who elect to receive hospice services no longer must waive the right to all other services related to the individual's diagnosis of a terminal illness or condition, including treatment. ***Possible Action Needed & Status (date)*** ▪ Determine if MPA already does or wishes to offer these optional services. ▪ Meeting scheduled for 10/1/2010 to examine requirements.	**3/23/2010** **unless state legislation is required (then, 7/1/2011)**	**MaryAnne Lindeblad**	**Gail Kreiger**	**T**			
	I-23. COMMUNITY FIRST CHOICE OPTION [§2401 OF PPACA AND § 1205 OF HCERA]—<u>OPTIONAL</u> States can offer home and community-based personal care attendant services as an optional benefit to Medicaid beneficiaries whose income does not exceed 150% of FPL, or if greater, the income level applicable for an individual who has been determined to require the level of care offered in a hospital, nursing facility, ICF/MR, or IMD. States electing this option will receive an increased 6% FMAP for these services. ***Possible Action Needed & Status (date)*** ▪ Coordinate with ADSA as needed.	**10/1/2011**	**ADSA**	**ADSA**	**O**			
	I-24. STATE OPTION TO PROVIDE HEALTH HOMES FOR ENROLLEES WITH CHRONIC CONDITIONS [§ 2703) OF PPACA]—<u>OPTIONAL</u>	**1/1/2011**	**MaryAnne Lindeblad;**	**Shirley Munkberg**	**P**			

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	Establishes a Medicaid state plan option, beginning January 1, 2011, for individuals with chronic conditions to designate a "health home" to coordinate the delivery of their health care. Eligible individuals are people eligible for Medicaid who have (1) at least 2 chronic conditions; (2) 1 chronic condition and are at risk for having a second chronic condition; or (3) a serious and persistent mental health (MH) condition. Chronic conditions will be defined by HHS, but must include: MH condition, substance use disorder, asthma, diabetes, heart disease, or overweight/obesity (BMI over 25). States will receive 90% FMAP for services for first 8 quarters. HHS Secretary may award planning grants to the states for developing their health home programs. Each state must match the federal contribution using its normal matching rate. The total payments made to the states will not exceed $25 million. ***POSSIBLE ACTION NEEDED & STATUS (DATE)*** ▪ Coordinate with HCA, DOH, and Health Care Cabinet staff, as necessary.		**Richard Onizuka**					
	I-25. REMOVAL OF BARRIERS TO PROVIDING HOME- AND COMMUNITY-BASED SERVICES [§ 2402 OF PPACA] Federal oversight of all HCBS: HHS must promulgate regulations that support flexible, consumer-oriented HCBS services funded by both Medicaid and other sources. Also modifies the 1915(i) benefits package set forth in the DRA which, e.g., (1) goes beyond the listed services and permits coverage of any services that could be approved under 1915(c); (2) provides the option for clients to enroll simultaneously in various waivers; (3) removes the options to limit enrollment (no caps!) or waive statewideness; (4) allows waiver of comparability for individuals who would meet 1915(c) eligibility (i.e., institutional level care required) so long as the services are in the scope that can be Secretary approved and don't include room and board; etc. Also creates a new Medicaid eligibility group. See Section I.A.2 above for more detail. ***POSSIBLE ACTION NEEDED & STATUS (DATE)*** ▪ Support and coordinate with ADSA as needed.	**7/1/2010** **(1st day of the 1st FFY quarter that begins after the date of enactment)**	**ADSA; MPA Support (MaryAnne Lindeblad; Manning Pellanda)**	**ADSA; MPA Support (Gail Kreiger; Mary Wood)**	**O, T**			
	I-26. CLARIFICATION OF THE DEFINITION OF MEDICAL ASSISTANCE [§ 2304 OF PPACA]	**3/23/2010**	**MPA AAGs**		**O, T**			

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	Clarifies that the definition of "medical assistance" in Section 1905(a) of the Social Security Act (SSA) and as used throughout the SSA includes both the payment of part or all of the cost of care and services or the care and services themselves, or both. ***POSSIBLE ACTION NEEDED & STATUS (DATE)*** ▪ Determine how to ensure that needed services are actually provided.							
	C. MEDICAID FINANCING							
	1. PAYMENTS TO STATES							
	I-27. ADDITIONAL FEDERAL FINANCIAL ASSISTANCE UNDER HEALTH REFORM [§§ 2001 AND 10201 OF PPACA AND 1201 AND 1202 OF HCERA] Expansion states will receive transitional increased FMAP between 1/1/2014 and 12/31/2015 for childless adults who were not newly eligible (because they were offered full Medicaid benefits prior to NHR). Other states (including WA) will receive 100% FMAP for the cost of providing benchmark coverage to newly eligible individuals from 2014 through 2016, with gradual decreases in FMAP until 2020 and thereafter when it will be 90%. Increased FMAP not available for DSH, CHIP, and payments under Medicaid based on the CHIP enhanced FMAP rate. No increased FMAP during early expansion period for the newly eligible population. Limits state's ability to increase the share of Medicaid expenditures from political sub-divisions (like counties) beyond what was in place as of 12/31/2009 to be eligible for an increase in the FMAP. ***POSSIBLE ACTION NEEDED & STATUS (DATE)*** ▪ Re-clarify with CMS that WA is <u>not</u> an expansion state (?)	**1/1/2014** **and annually thereafter**	**Manning Pellanda; Thuy Hua-Ly; Rich Campbell**	**Mary Wood; Annette Meyer; Cathie Ott**	**P**			
	I-28. INCENTIVES FOR STATES TO OFFER HOME- AND COMMUNITY-BASED SERVICES AS LONG-TERM CARE ALTERNATIVE TO NURSING HOMES [§ 10202 OF PPACA] Incentive payments to states (available for a five-year period) to increase percentage of long-term care expenditures spent on noninstitutional services. ***POSSIBLE ACTION NEEDED & STATUS (DATE)***	**10/1/2011**	**ADSA**	**ADSA**	**O**			

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	▪ Coordinate with ADSA as needed.							
	I-29. DISPROPORTIONATE SHARE HOSPITAL PAYMENTS [§§ 2551 AND 10201(E) OF PPACA AND 1203 OF HCERA] $500 million FFY 2014 DSH reductions based on methodology developed by Secretary. $600 million in FFY 2015 DSH reductions. $600 million in FFY 2016 DSH reductions. $1.8 billion in FFY 2017 DSH reductions. $5 billion in FFY 2018 DSH reductions. $5.6 billion in FFY 2019 DSH reductions. $5.6 billion in FFY 2019 DSH reductions. $4 billion in FFY 202 DSH reductions. Largest percentage reductions will be imposed on states that have the lowest percentage of uninsured or states that don't target DSH payments to hospitals with high Medicaid volumes and uncompensated care. ***POSSIBLE ACTION NEEDED & STATUS (DATE)*** ▪ Consult with C&B.	**10/1/2013** **10/1/2014** **10/1/2015** **10/1/2015** **10/1/2017** **10/1/2018** **10/1/2019**	**Thuy Hua-Ly**	**Sandy Stith**	**A, P**			
	I-30. SPECIAL FMAP ADJUSTMENT FOR STATES RECOVERING FROM A MAJOR DISASTER [§ 2006 OF PPACA] Currently, only Louisiana will qualify for continued increased FMAP under ARRA after 12/31/2010. In the future, other states may quality for the special disaster relief FMAP increase if they meet the two listed requirements. ***POSSIBLE ACTION NEEDED & STATUS (DATE)*** ▪ None	**1/1/2011**			**NP**			
	2. OTHER PAYMENTS							
	I-31. PAYMENTS FOR PRIMARY CARE PROVIDERS [§ 1202 OF HCERA] Requires that Medicaid payment for primary care services furnished in CY 2013 and 2014 must be no less than the payment rate for such services by physicians under Medicare. Capitation payments for managed care plans must be adjusted to reflect this level of reimbursement for primary care physicians. The FMAP for the portion of the payments for primary care services that exceeds the state's rate under the state plan as of 7/1/2009, up to the Medicare payment level, will be paid 100% by the federal government. Defines primary care physicians and identifies the procedure	**1/1/2013** **for services provided in CY 2013** **1/1/2014**	**Thuy Hua-Ly; MaryAnne Lindeblad (HO rate structure)**	**Scott Palafox; Michael Paulson**	**P**			

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	codes that are considered primary care services (i.e., E&M codes and services related to immunizations). ***POSSIBLE ACTION NEEDED & STATUS (DATE)*** ▪ Make any necessary changes to rate setting methodologies.	**for services provided in CY 2014**						
	I-32. PAYMENTS TO PROVIDERS FOR HEALTH CARE-ACQUIRED CONDITIONS [§§ 2702 AND 10303 OF PPACA] Prohibits payments to states for Medicaid services related to health care acquired conditions (HACs). HHS will issue regulations by 7/1/2011. ***POSSIBLE ACTION NEEDED & STATUS (DATE)*** ▪ Make any necessary changes to policies, procedures, WAC, systems, etc related to "never" events and HACs to ensure non-payment. ▪ Per C&B #41, applies more broadly than hospitals (i.e., broader than Medicare HACs). ▪ On July 12, 2010, CMS issued a Fed. Reg. notice soliciting information from States about how they currently identify hospital-acquired conditions.	**7/1/2011**	**Jeff Thompson**	**Carolyn Adams, Ellen Silverman**	**A**			
	3. PRESCRIPTION DRUGS							
✓	**I-33. PRESCRIPTION DRUG REBATES [§§ 2501 OF PPACA AND 1206 OF HCERA]** Increases the minimum rebate percentage from 15.1% to 23.1% of the average manufacturer price (AMP), increases the minimum rebate percentage for generic drugs from 11% to 13% of AMP, and caps the maximum rebate amount at 100% of the AMP. Rebate for clotting factors and FDA-approved outpatient drugs exclusively for pediatric indications increases to 17.1%. The increases apply to rebate periods after 12/31/ 2009. Increases will go solely to the federal government and payments to the States will be reduced by the amount of the increase in the minimum rebate amount. The payment reduction will be an overpayment disallowed against the quarterly draw and is not subject to reconsideration. Under HCERA, the definition of a new formulation of existing drugs is narrowed for purposes of applying the additional rebate.	**1/1/2010** **but Medicaid managed care rebates begin 3/23/2010**	**Thuy Hua-Ly**	**Myra Davis**	**A**			

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	Rebates are extended to apply to drugs paid for by Medicaid managed care organizations. ***POSSIBLE ACTION NEEDED & STATUS (DATE)*** ▪ Make any necessary changes to rates, policies, procedures, WAC, systems, etc							
	I-34. ELIMINATION OF EXCLUSION OF COVERAGE OF CERTAIN DRUGS [§ 2502 OF PPACA] Medicaid programs that cover prescription drugs must also cover smoking cessation drugs, as well as barbiturates and benzodiazepines. ***POSSIBLE ACTION NEEDED & STATUS (DATE)*** ▪ Make any necessary changes to policies, procedures, WAC, systems, etc	**1/1/2014**	**Thuy Hua-Ly**	**Myra Davis**	**A**			
	I-35. PROVIDING ADEQUATE PHARMACY REIMBURSEMENT [§ 2503 OF PPACA] Changes the federal upper limit (FUL) to no less than 175% of the weighted average (determined on the basis of utilization) of the most recently reported monthly AMP. Restores the pre-DRA definition of multiple source drugs as 3 therapeutic and pharmaceutically equivalent products. Also includes technical changes to the FUL formula such as a smoothing process for average manufacturer prices to reduce short-term volatility and clarifies what the AMP excludes. ***POSSIBLE ACTION NEEDED & STATUS (DATE)*** ▪ Make any necessary changes to rates, policies, procedures, WAC, systems, etc	**1/1/2011**	**Thuy Hua-Ly**	**Myra Davis**	**A**			
	I-36. 340B PRESCRIPTION DRUG DISCOUNT PROGRAM EXPANSION [§§ 7101-7103 OF PPACA AND 2302 OF HCERA] Expands the list of covered entities eligible to receive 340B discounts to include (1) certain children's and free-standing cancer hospitals excluded from the Medicare prospective payment system, (2) critical access and sole community hospitals, and (3) rural referral centers. HHS must develop systems to improve compliance and program integrity activities for manufacturers and covered entities, plus procedures to resolve disputes. GAO must submit a report about whether those who receive	**1/1/2010**	**Thuy Hua-Ly**	**Allen Hall**	**A**			

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	services through 340B covered entities receive optimal health care services. ***POSSIBLE ACTION NEEDED & STATUS (DATE)*** ▪ Make any necessary changes to policies, procedures, WAC, systems, etc							
	D. PROGRAM INTEGRITY							
	I-37. EXPANSION OF THE RECOVERY AUDIT CONTRACTOR (RAC) PROGRAM [§ 6411 OF PPACA] States must establish contracts, similar to those the HHS Secretary has for the Medicare RAC program, with one or more RACs to identify underpayments, overpayments, and recoupments for services provided under the State Plan and waivers. States must also make certain assurances related to their RAC programs. Payments made to RACs will be from amounts recovered (on contingency). Audit recovery efforts must be coordinated with other contractors or entities performing audits, including law enforcement (e.g., FBI, DOJ, OIG, MFCU). RAC will be expanded to Medicare Parts C and D. HHS must submit an annual report to Congress. ***Possible Action Needed & Status (date)*** ▪ Amend State Plan to include this requirement. ▪ Review forthcoming HHS regulations on the RAC program expansion, including FFP conditions. ▪ Outreach to providers to explain the scope, purpose, and consequences of RAC audits. ▪ Coordinate tribal education with DBHR as needed.	**12/31/2010**	**Cathie Ott**	**TBD**	**P**			
	I-38. TERMINATION OF PROVIDER PARTICIPATION UNDER MEDICAID AND CHIP IF TERMINATED UNDER MEDICARE OR OTHER STATE PLAN [§ 6501 OF PPACA] Requires termination of contracts with providers who were excluded or terminated from Medicaid or Medicare participation. ***Possible Action Needed & Status (date)*** ▪ Amend State Plan. ▪ Modify provider enrollment process as needed.	**1/1/2011**	**Cathie Ott**	**TBD**	**T**			

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	I-39. MEDICAID EXCLUSION FROM PARTICIPATION RELATING TO CERTAIN OWNERSHIP, CONTROL, AND MANAGEMENT AFFILIATIONS [§ 6502 OF PPACA] Requires disclosure by and exclusion of providers who are (1) affiliated with any entity that owns, controls, or manages and entity that has unpaid overpayments; (2) are suspended, excluded, or terminated from Medicaid participation; or (3) are affiliated with an individual or entity suspended, excluded or terminated from Medicaid. ***Possible Action Needed & Status (date)*** ▪ Amend State Plan. ▪ Modify provider enrollment process as needed.	**1/1/2011**	**Manning Pellanda**	**Diane Getchman**	**T**			
	I-40. BILLING AGENTS, CLEARINGHOUSES, OR OTHER ALTERNATE PAYEES REQUIRED TO REGISTER UNDER MEDICAID [§ 6503 OF PPACA] Requires any agents, clearinghouses, or other alternate payees that submit claims on behalf of Medicaid health care providers to register with the state and the Secretary in a form and manner the Secretary is required to specify ***Possible Action Needed & Status (date)*** ▪ Review forthcoming regulations. ▪ Amend State Plan.	**1/1/2011**	**Manning Pellanda**	**Diane Getchman**	**T**			
	I-41. REQUIREMENT TO REPORT EXPANDED SET OF DATA ELEMENTS UNDER MMIS TO DETECT FRAUD AND ABUSE [§ 6504 OF PPACA] Requires states to collect and submit managed care encounter data through their MMISs for the purposes of program integrity, program oversight, and administration. The HHS Secretary will determine the data needed and how frequently they must be submitted. Beginning 1/1/2010, Medicaid managed care plans must submit required data elements. ***Possible Action Needed & Status (date)*** ▪ Currently doing. Review forthcoming regulations and ensure compliance.	**1/1/2010**	**Cathie Ott**	**Karen DeLeon**	**T**			

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	I-42. PROHIBITION ON PAYMENTS TO INSTITUTIONS OR ENTITIES LOCATED OUTSIDE OF THE U.S. [§6505 OF PPACA] Prohibits states from making any payments for items or services supplied to beneficiaries under a Medicaid state plan or waiver to any financial institution or entity located outside of the United States. ***Possible Action Needed & Status (date)*** ▪ Amend State Plan. ▪ Revise out-of-state and out-of-country WACs.	**1/1/2011**	**MaryAnne Lindeblad**	**Gail Kreiger**	**A, T**			
	I-43. OVERPAYMENTS [§ 6506 OF PPACA] States have one year, rather than the 60 days under the previous law, to repay the federal share after discovery of a potential overpayment. In the case of potential fraud, where the state has not yet recovered the funds because there has not yet been a final judicial determination, the state would not have to repay the federal share until 30 days after a final judgment is entered. ***Possible Action Needed & Status (date)*** ▪ Amend State Plan ▪ ???.	**3/23/2010**	**Annette Meyer**	**Sharon Holler**	**P**			
	I-44. MANDATORY STATE USE OF NATIONAL CORRECT CODING INITIATIVES (NCCI) [§ 6507 PPACA] NCCI must be used for claims filed on or after 10/1/2010. By 9/1/2010, the HHS Secretary must (1) identify NCCI methodologies compatible with Medicaid claims, and (2) identify methodologies applicable to Medicaid, but for which no Medicare NCCI methodologies had been established. Secretary must notify states of NCCI methodologies (or successor initiatives) applicable to Medicaid that were identified and how states are to incorporate those methodologies into their Medicaid claims processing systems. Secretary must report to Congress by 3/1/2011. ***Possible Action Needed & Status (date)*** ▪ Review Secretary's forthcoming guidance and comply as needed.	**10/1/2010**	**Cathie Ott**	**Karen DeLeon**	**T**			

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	I-45. GENERAL EFFECTIVE DATE FOR MEDICAID AND CHIP PROGRAM INTEGRITY ACTIVITIES [§ 6508 OF PPACA] States are be required to implement PPACA's Medicaid Program Integrity Sections by January 1, 2011, regardless of whether final regulations were issued. ***Possible Action Needed & Status (date)*** ▪ See above.	**1/1/2011** **or, if legislation required, 7/1/2011**	**Cathie Ott**	**Cathie Ott**	**T**			
	I-46. PROVIDER SCREENING AND OTHER ENROLLMENT REQUIREMENTS UNDER MEDICARE, MEDICAID AND CHIP [§§ 6401 AND 10603 OF PPACA] Imposes new requirements for medical providers and suppliers seeking enrollment in Medicare, Medicaid and/or CHIP. These include licensure checks, criminal background checks, fingerprinting, site visits, database checks, etc. To cover costs, new institutional providers/suppliers must pay application fees. Secretary may also impose a moratorium on enrolling new high-risk providers. Providers within a particular industry or category must establish compliance programs. ***Possible Action Needed & Status (date)*** ▪ Amend State Plan and make any necessary changes to the provider enrollment process.	**3/23/2011** **for new providers;** **3/23/2012** **for existing ones**	**Manning Pellanda**	**Diane Getchman**	**A, T**			
	I-47. ENHANCED MEDICARE AND MEDICAID PROGRAM INTEGRITY PROVISIONS [§§ 6402 OF PPACA AND 1302 OF HCERA] **a.** ***Data Matching***: Establishes an "Integrated Data Repository (IDR)" to include consolidated claims and data from Medicare, Medicaid, and CHIP, as well as other claims data paid by the federal government (e.g., VA, DOD, IHS, SSA). Data sharing agreements required between all these agencies to identify waste, fraud, and abuse. The priority is on the integration of Medicare and Medicaid claims data although CHIP data will be integrated as appropriate. **b.** ***Access to Data***: OIG and DOJ will have access to IDR claims data for enforcement and oversight activities. OIG may also obtain information from providers, suppliers, and beneficiaries to validate claims. **c.** ***Beneficiary Participation in Health Care Fraud Scheme***: HHS Secretary must	**1/1/ 2011** **(States must implement fraud, waste, and abuse programs by this date; effective dates of specific provisions are**	**Cathie Ott**	**Shaundra Moss**	**P**			

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	impose administrative penalties on beneficiaries who knowingly participate in health care fraud offenses. Beneficiaries must also return overpayments within 60 days of receipt. **d.** ***National Provider Identifier (NPI)***: Secretary must issue regulations before 1/1/2011 mandating that all Medicare and Medicaid providers include NPIs on all payment claims and enrollment applications. **e.** ***Withholding FFP for Failure to Report Encounter Data in MMIS***: Secretary may withhold FFP if encounter data is not submitted timely. **f.** ***Permissive Exclusions***: Allows HHS OIG to exclude providers (including MCOs and their participating providers) from federal health care program participation if they make false statements or misrepresentations on applications to enroll. **g.** ***Civil Monetary Penalties (CMPs)***: Specifies the CMPs provided for false claims, etc; adds additional actions and individuals subject to CMPs, including individuals who order a medical service when they are not enrolled as a provider in a Federal health care program, individuals who make false statements on applications or contracts to participate in a Federal health care program, and individuals who are aware of an overpayment and do not return it. **h.** ***Testimonial Subpoena Authority***: Grants the Secretary specific subpoena authority, which she may delegate to HHS/OIG and the CMS administrator for program exclusion investigations. **i.** ***Surety Bond Requirements***: Commensurate with billing volume, DME, Home Health Agency, and other "risky" providers must be bonded. **j.** ***Suspension of Medicare and Medicaid payments pending investigation of credible allegations of fraud***: Permits nonpayment of claims during an investigation. **k.** ***Performance Statistics***: Medicare and Medicaid Integrity Program contractors must report (1) the number and amount of overpayments recovered; (2) the number of fraud referrals; and (3) return on investment for these activities. HHS Secretary must evaluate the contractors every 3 years and report to Congress within 6 months of each FFY end.	**unclear)**						

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	I. ***Increased Medicare & Medicaid Program Integrity Funding***: Funding increases every FFY after FFY 2010 indexed to changes in the CPI. ****Possible Action Needed & Status (date)*** ▪ Monitor issuance of related regulations.							
	I-48. ELIMINATE DUPLICATION BETWEEN THE HEALTHCARE INTEGRITY AND PROTECTION DATA BANK (HIPDB) AND THE NATIONAL PRACTITIONER DATA BANK (NPDB) [§6403 OF PPACA] Secretary must establish a process to end the HIPDB and merge it with the NPDB information, after providing the NPDB with all information reported to the national health care fraud and abuse data collection program regarding final adverse actions against providers. ****Possible Action Needed & Status (date)*** ▪ Coordinate with DOH as needed.	**3/1/2011**	**DOH; MPA Support (Cathie Ott; Manning Pellanda)**	**DOH; MPA Support (Cathie Ott; Manning Pellanda)**	**T**			
	I-48A. FACE-TO-FACE ENCOUNTERS FOR HOME HEALTH & DME ENCOUNTERS (§6407 OF PPACA] Requires a physician, a nurse practitioner or clinical nurse specialist working in collaboration with the physician, a nurse-midwife or a physician assistant under the supervision of the physician to have had a face-to-face encounter with the Medicare or Medicaid recipient prior to making a certification for home health services or writing an order for durable medical equipment. The face-to-face encounter must occur during the six-month period preceding such written order or certification. The Secretary also has the authority to apply this face-to-face encounter requirement to other items and services under Medicare. This section applies to home health certifications made after January 1, 2010 and to durable medical equipment orders made after March 23, 2010. ****Possible Action Needed & Status (date)*** ▪ Revise billing instructions, WAC, and establish an auditing function	**1/1/2010** **and 3/23/2010**	**DME: Rich Campbell; MaryAnne Lindeblad; Jeff Thompson** **Home Health: ADSA**	**DME: Cathie Ott; Gail Kreiger**	**P**			
	I-49. IMPROVING NURSING HOME TRANSPARENCY, ENFORCEMENT AND STAFF TRAINING [§§ 6101-6107, 6111-6114, AND 6121 OF PPACA]	**3/23/2011**	**ADSA; MPA Support**	**ADSA; MPA Support (Gail**	**O**			

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	Enhances certain accountability requirements for Medicare certified SNFs and Medicaid certified NFs. Requires SNFs and NFs to maintain and make available additional information on facility ownership and organizational structure, as well as to establish new staff compliance and ethics training programs. Includes notification of facility closure requirements; demonstration projects on best practices for culture change and use of IT in SNFs and NFs; and revision of nurse aide training, competency, and evaluation requirements to include dementia and abuse prevention. ***Possible Action Needed & Status (date)*** ▪ Coordinate with ADSA as needed.		**(MaryAnne Lindeblad)**	**Kreiger)**				
	E. MEDICAID DEMONSTRATIONS & GRANT FUNDING [*SEE FFIS SPECIAL ANALYSIS 10-02 (5/24/2010) FOR AN INVENTORY OF FUNDING OPPORTUNITIES*]							
	I-50. MONEY FOLLOWS THE PERSON [§ 2403 OF PPACA] Amends the DRA to: (1) extend through FY2016 the Money Follows the Person Rebalancing Demonstration; and (2) reduce the residential stay requirement from 6 months to 90 days. ***Possible Action Needed & Status (date)*** ▪ Coordinate with ADSA as needed.	**4/22/2010** **(30 days after PPACA enactment)**	**ADSA; MPA Support (MaryAnne Lindeblad)**	**ADSA; MPA Support (Gail Kreiger)**	**O**			
	I-51. STATE OPTION TO PROVIDE HEALTH HOMES FOR ENROLLEES WITH CHRONIC CONDITIONS [§ 2703 OF PPACA] Allows states to provide coordinated care through a health home for individuals with chronic conditions. Provides 90% FMAP for first 8 quarters for health home services including care management, care coordination and health promotion, transitional care, patient and family support and referral to community and social support services and use of HIT where feasible and appropriate. ***Possible Action Needed & Status (date)*** ▪ Determine whether MPA would like to exercise this option and coordinate with HCA, DOH, and Health Care Cabinet staff, as necessary.	**1/1/2011**	**MaryAnne Lindeblad**	**Shirley Munkberg**	**P**			

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	I-52. HEALTH HOMES FOR ENROLLEES WITH CHRONIC CONDITIONS: PLANNING GRANTS [§ 2703 OF PPACA] Secretary may award planning grants to the states for developing their health home programs. Each state must match the federal contribution using its normal matching rate. The total payments made to the states will not exceed $25 million. ***Possible Action Needed & Status (date)*** ▪ Determine whether MPA would like to exercise this option and coordinate with HCA, DOH, and Health Care Cabinet staff, as necessary.	**1/1/2011**	**MaryAnne Lindeblad**	**Shirley Munkberg**	**P**			
	I-53. DEMONSTRATION PROJECT TO EVALUATE INTEGRATED CARE AROUND HOSPITALIZATION [§ 2704 OF PPACA] Directs the Secretary to establish a demonstration project to evaluate the use of bundled payments for the provision of integrated care for a Medicaid beneficiary: (1) with respect to an episode of care that includes a hospitalization; and (2) for concurrent physicians services provided during a hospitalization. Must be budget neutral. 8 State grantees. ***Possible Action Needed & Status (date)*** ▪ Determine whether MPA should apply.	**1/1/2012 – 12/31/2016**	**Thuy Hua-Ly; Jeff Thompson**	**Carolyn Adams**	**A**			
	I-54. MEDICAID GLOBAL PAYMENT SYSTEM DEMONSTRATION PROJECT [§ 2705 OF PPACA] Establishes a demonstration project, in coordination with the CMS Innovation Center, in up to five States that would allow participating States to adjust their current payment structure for safety net hospitals from a fee-for-service model to a global capitated payment structure. ***Possible Action Needed & Status (date)*** ▪ Determine whether MPA should apply. NOT AT THIS TIME (7/1/10)	**10/1/2009 (FFY 2010) – 2012 FFY**			**NP**			
	I-55. PEDIATRIC ACCOUNTABLE CARE ORGANIZATION (ACO) DEMONSTRATION PROJECT [§ 2706 OF PPACA] Establishes a demonstration project that allows qualified pediatric providers to be	**1/1/2012 – 12/31/2016**	**MaryAnne Lindeblad**	**Barb Lantz**	**A**			

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	recognized and receive payments as ACOs under Medicaid. The pediatric ACO would be required to meet certain performance guidelines. Pediatric ACOs that met these guidelines and provided services at a lower cost would share in those savings. Budget saving requirement. ***Possible Action Needed & Status (date)*** ▪ Determine whether MPA should apply.							
	I-56. MEDICAID EMERGENCY PSYCHIATRIC DEMONSTRATION PROJECT [§ 2707 OF PPACA] Requires the Secretary of HHS to establish a three-year Medicaid demonstration project in up to eight States. Participating States would be required to reimburse certain institutions for mental disease (IMDs) for services provided to Medicaid beneficiaries between the ages of 21 and 65 who are in need of medical assistance to stabilize an emergency psychiatric condition. $75 million for FFY 2011. Such funds will remain available for obligation for 5 years through December 31, 2015. ***Possible Action Needed & Status (date)*** ▪ Consult with DBHR.	**10/1/2010** **(FFY 2011)**	**DBHR; MPA support (MaryAnne Lindeblad)**	**DBHR; MPA support (MaryAnne Lindeblad)**	**O, T**			
✓	**I-57. GRANTS FOR SCHOOL-BASED HEALTH CENTERS [§ 4101(A) OF PPACA]** Requires the Secretary to establish a program to award grants to eligible entities to support the operation of school-based health centers. $50 million annually. Preference given to school-based health centers (SBHCs) serving large populations of Medicaid or CHIP children. ***Possible Action Needed & Status (date)*** ▪ Provide letter of support to external grant applicants, as appropriate.	**10/1/2009** **(FFY 2010) – FFY 2013**	**SBHCs; MPA Support (MaryAnne Lindeblad)**	**SBHCs; MPA Support (Chris Bess)**	**O**			
✓	**I-58. ORAL HEALTHCARE PREVENTION ACTIVITIES [§ 4102 OF PPACA]** Requires the Secretary, acting through the Director of CDC, to carry out oral health activities, including: (1) establishing a national public education campaign that is focused on oral health care prevention and education; (2) awarding demonstration grants for research-based dental caries disease management activities; (3) awarding grants for the development of school-based dental sealant programs; and (4)	**3/23/2010**	**DOH; MPA Support (MaryAnne Lindeblad)**	**DOH; MPA Support (John Davis)**	**O, T**			

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	entering into cooperative agreements with state, territorial, and Indian tribes or tribal organizations for oral health data collection and interpretation, a delivery system for oral health, and science-based programs to improve oral health. Requires the Secretary to: (1) update and improve the Pregnancy Risk Assessment Monitoring System as it relates to oral health care; (2) develop oral health care components for inclusion in the National Health and Nutrition Examination Survey; and (3) ensure that the Medical Expenditures Panel Survey by AHRQ includes the verification of dental utilization, expenditure, and coverage findings through conduct of a look-back analysis. ***Possible Action Needed & Status (date)*** ▪ Coordinate with DOH, CA, DEL, and Tribes as needed related to grants.							
	I-59. GRANTS FOR PREVENTION OF CHRONIC DISEASE [§ 4108 OF PPACA] Requires the Secretary to award grants to states to carry out initiatives to provide incentives to Medicaid beneficiaries who participate in programs to lower health risk and demonstrate changes in health risk and outcomes. $100 million for 5-year period (through 1/1/2016); state initiatives must last at least 3 years of the 5 year program. Beneficiary incentives will not be used for determining eligibility. ***Possible Action Needed & Status (date)*** ▪ Further analysis needed to determine whether MPA should apply.	**1/1/2011** **(no later than)**	**MaryAnne Lindeblad**	**Shirley Munkberg**	**A**			
	I-60. CONTINUE CHILDHOOD OBESITY DEMONSTRATION PROJECT [§ 4306 OF PPACA] CHIPRA required Secretary to initiate a demonstration to develop a comprehensive and systematic model for reducing child obesity. A total of $25 million was authorized for FFY 2009 to FFY 2013—this was pushed ahead by one year. Eligible entities are local government, health department or educational agency community. ***Possible Action Needed & Status (date)*** ▪ Monitor/await CMS guidance and support local entities as needed.	**10/1/2009** **(FFY 2010) – FFY 2014**	**Local Entities; MPA Support (MaryAnne Lindeblad)**	**Local Entities; MPA Support (Barb Lantz)**	**O, T**			
	I-61. IMPROVING ACCESS TO PREVENTIVE SERVICES FOR ELIGIBLE ADULTS IN MEDICAID [§ 4106 OF PPACA]	**1/1/2013**	**MaryAnne**	**Gail Kreiger**	**A**			

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	See Section I.B (Medicaid Benefits) above. ***Possible Action Needed & Status (date)*** ▪ Determine if MPA/its HO plans already do or wish to offer these optional services. Must ensure no cost-sharing for them.		**Lindeblad**					
	F. CHIP							
	I-62. ADDITIONAL FEDERAL FINANCING PARTICIPATION FOR CHIP [§§ 2101 AND 10203(C) OF PPACA] Extends the current reauthorization period of CHIP for two years, through 9/30/15. If not reauthorized, CHIP ends 10/1/2019. States must maintain income eligibility levels for CHIP through 9/30/2019. After 10/1/2013, the enrollment bonus payments end. CHIP eligibility based on MAGI after 1/1/2014. Children who become ineligible for Medicaid due to elimination of income disregards must be treated as a targeted low-income child eligible for CHIP (except kids of public employees or those in IMDs). Children who cannot enroll in CHIP because allotments are capped are deemed ineligible for CHIP and, therefore, eligible for tax credits in the exchanges. CHIP must be coordinated with the Exchange. Precludes transitioning coverage from CHIP to the Exchange without Secretarial certification of the plans available to children. Creates a new option for states to provide CHIP coverage to children of state employees eligible for health benefits if the state premium contribution for family coverage is less than 1997 levels (adjusted for inflation) or if the employee's premiums and cost sharing exceeds 5 percent of the family's income ***Possible Action Needed & Status (date)*** ▪ Ensure review of and compliance with these new provisions—COMPLETE	**2/4/2009** **(Changes effective retroactive to date of CHIPRA enactment)**	**Manning Pellanda**	**Mary Wood/ Kevin Cornell**	**C**			
	I-63. DISTRIBUTION OF CHIP ALLOTMENTS AMONG STATES [§§ 2101 AND 10203(D) OF PPACA] Enhanced FMAP for targeted low income children increased by 23%, subject to a cap of 100%, from FFY 2016 to 2019 but no increase in allotment.	**10/1/2015**	**Manning Pellanda**	**Mary Wood/ Kevin Cornell**	**T**			

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	Possible Action Needed & Status (date) ▪ ???							
	I-64. TECHNICAL CORRECTION TO CHIPRA [§ 2102 OF PPACA] **a.** Adjusts FFY 2010 CHIP allotments. **b.** Corrects section 505 of CHIPRA relating to lawfully residing immigrants. **c.** Adjustments to the Current Population Survey to identify "high performing" CHIPRA states. **d.** Mandates that alternative premiums/cost sharing provisions in Medicaid don't supersede protections in these areas for Native Americans. ***Possible Action Needed & Status (date)*** ▪ Ensure review of and compliance with corrected provisions—COMPLETE	**2/4/2009** **(Changes effective retroactive to date of CHIPRA enactment)**	**Manning Pellanda**	**Mary Wood/ Kevin Cornell**	**C**			
	I-65. EXTENSION OF FUNDING FOR CHIP THROUGH FY2015 AND OTHER RELATED PROVISIONS [§§ 10203(A), 10203(B), AND 10202(D)] **a.** Revisions to the Child Health Quality Measurement Initiative, including the requirement that qualified health plans seeking certification from the Secretary to participate in the Exchange must report these pediatric quality reporting measures at least annually. **b.** Participation in, and Premium Assistance for, Employer-Sponsored Insurance (See Section I.B (Medicaid Benefits/Premium Assistance) above for more detail). **c.** Definition of CHIP Eligible Children, making two exceptions to the prohibition against enrolling children of state agency employees. **d.** CHIP Annual Allotments, including an increase in appropriated amounts ($140 million) for outreach and enrollment grants (80% of which will go to state and local governments and CBOs, with 10% targeted for outreach to Native American children) through FFY 2015 ***Possible Action Needed & Status (date)*** ▪ Ensure review of and compliance with these new provisions.	**2/4/2009** **(Changes effective retroactive to date of CHIPRA enactment)**	**a. MaryAnne Lindeblad** **b. Thuy Hua-Ly** **c. Manning Pellanda** **d. MaryAnne Lindeblad**	**a. Barb Lantz** **b. Andy Renggli** **c. Mary Wood/Kevin Cornell** **d. Tyron Nixon**	**A, T**			
	G. MISCELLANEOUS MEDICAID PROVISIONS							

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	I-66. MEDICAID IMPROVEMENT FUND (MIF) RESCISSION [§ 2007 OF PPACA] $700 million available from 2014 to 2018 for this program, including contractor oversight and demonstration project evaluation, was rescinded. ***Possible Action Needed & Status (date)*** ▪ Revise any previous plans to pursue this funding—COMPLETE	3/23/2010			C			
	I-67. REMOVAL OF BARRIERS TO PROVIDING HOME- AND COMMUNITY- BASED SERVICES [§ 2402 OF PPACA] See Section I.A.2 (Optional Eligibility Expansion Opportunities) and Section I.B (Medicaid Benefits) above.	7/1/2010	**ADSA; MPA Support (MaryAnne Lindeblad; Manning Pellanda)**	**ADSA; MPA Support (Gail Kreiger; Mary Wood)**	O, T			
	I-68. FUNDING TO EXPAND STATE AGING AND DISABILITY RESOURCE CENTERS [§ 2405 OF PPACA] $10 million for each of FFY 2010 through FFY 2014 to carry out Aging and Disability Resource Center (ADRC) initiatives. ***Possible Action Needed & Status (date)*** ▪ None?	3/23/2010	**ADSA**	**ADSA**	O			
	I-69. SENSE OF THE SENATE REGARDING LONG-TERM CARE [§ 2406 OF PPACA] Congress should comprehensively address long-term services and supports in a way that guarantees elderly and disabled individuals the care they need, and that makes long term services and supports available in the community as well as in institutions. ***Possible Action Needed & Status (date)*** ▪ None	3/23/2010	**ADSA**	**ADSA**	O			
	I-70. ADULT HEALTH QUALITY MEASURES [§ 2701 OF PPACA] Establishes the Medicaid Quality Measurement Program no later than 12 months after the release of the recommended core set of adult health quality measures. Requires the Secretary to create procedures to identify health care quality	1/1/2011 **(Measures identified and made available**	**MaryAnne Lindeblad**	**Barb Lantz**	A, T			

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	measurements for Medicaid-eligible adults similar to the procedures already underway for children; to establish procedures for and provide grants to states to collect and voluntarily report health care quality data for Medicaid-eligible adults; and to, in consultation with states, identify specific preventable health care acquired conditions that would prohibit payments for services related to such conditions. ***Possible Action Needed & Status (date)*** ▪ Participate in comment period on proposed measures.	**for comment by this date)**						
	I-71. PAYMENTS TO PROVIDERS FOR HEALTH CARE-ACQUIRED CONDITIONS [§§ 2702 AND 10303 OF PPACA] See section I.C.2 (Medicaid Financing, Other Payments) above.	**7/1/2011**	**Jeff Thompson**	**Carolyn Adams, Ellen Silverman**	**A**			
	I-72. MACPAC ASSESSMENT OF POLICIES AFFECTING ALL MEDICAID BENEFICIARIES [§§ 2801 AND 399V-4 OF PPACA] Broadens the scope of the Medicaid and CHIP Payment and Access Commission (MACPAC) to include adult services (including duals) and clarifies the topics for review including eligibility policies, enrollment and retention processes, coverage policies, quality of care, and interactions with Medicare and Medicaid. (Provides appropriations of $11 million for FY 2010 with $9 million from Medicaid and $2 million from CHIP). ***Possible Action Needed & Status (date)*** ▪ Monitor. MACPAC has yet to issue a report, and it is uncertain the impact its reports will have.	**3/23/2010**	**Thuy Hua-Ly**	**Andy Glenn**	**T**			
	I-73. ESTABLISHMENT OF CENTER FOR MEDICARE AND MEDICAID INNOVATION (CMI) WITHIN CMS [§§ 3021 AND 10306 OF PPACA] Establishes the CMS Innovation Center designed to test, evaluate, and expand in Medicare, Medicaid, and CHIP different payment structures and methodologies to foster patient-centered care, improve quality, and slow Medicare costs growth. Payment reform models that improve quality and reduce the rate of costs could be expanded throughout the Medicare, Medicaid, and CHIP programs. The Secretary has authority to limit the testing of models to selected geographic areas. An	**1/1/2010** **for establishment of the CMI**	**MaryAnne Lindeblad**	**Barb Lantz**	**A, T**			

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	appropriation of $5 million for the design, implementation, and evaluation of models for FY2010; $10 billion for FY2011 through FY2019; and $10 billion for each subsequent 10-year fiscal period beginning with 2020. Budget neutrality is not required. ***Possible Action Needed & Status (date)*** ▪ Determine, if there is interest, how MPA programs may serve as a model.							
	I-74. GAO STUDY AND REPORT ON CAUSES OF ACTION [§ 3512 OF PPACA] GAO is required to conduct a study to determine if the development, recognition, or implementation of guidelines or other standards under selected provisions in the law might result in new causes of action or claims. The GAO study will include three Medicaid related (adult quality measures, HACs, and CMI) and 11 other non-Medicaid related provisions in the law (e.g., hospital readmission reduction program). ***Possible Action Needed & Status (date)*** ▪ Monitor.	**3/23/2012**	**MaryAnne Lindeblad**	**Barb Lantz**	**T**			
	I-75. PUBLIC AWARENESS OF PREVENTIVE- AND OBESITY- RELATED SERVICES [§ 4004(I) OF PPACA] Requires the Secretary to provide guidance and relevant information to states and health care providers regarding preventive and obesity-related services that are available to Medicaid enrollees, including obesity screening and counseling for children and adults. Each State must design a public awareness campaign about the availability and coverage of such services. The Secretary must report to Congress on these efforts beginning no later than 1/1/2011 and every three years thereafter until 1/1/2017. Appropriation of sums necessary to carry out these provisions is authorized. ***Possible Action Needed & Status (date)*** ▪ Monitor and coordinate with DOH as needed.	**1/1/2011 – 1/1/2017**	**MaryAnne Lindeblad**	**Barb Lantz**	**T**			
	I-76. SECTION 1115 WAIVER TRANSPARENCY [§ 10201 OF PPACA]	**9/20/2010**	**Roger Gantz**	**Jenny Hamilton**	**P**			

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	Secretary must, within 180 days of enactment, adopt regulations specifying a public notice and comment process for 1115 waivers, including a public notice and participation process at the federal level after the application is submitted. The provisions also require the regulations to set forth processes for implementation reports from the state and for federal evaluations of the waivers. ***Possible Action Needed & Status (date)*** ▪ Comply with regulations for the BH/MCS waiver.							
✓	**I-77. WAIVER FOR STATE INNOVATION [§ 1332 OF PPACA]** Allows a process for states to apply for waiver of the requirements related to health insurance coverage for plan years beginning on or after 1/1/2017 and set up their own health care systems as long as they meet certain ACA requirements. A state may apply for waivers of the following requirements: • Requirements for Qualified Health Benefits Plans • Requirements for Health Insurance Exchanges • Requirements for reduced cost-sharing in qualified health benefits plans • Requirements for premium subsidies • Requirements for the employer mandate • Requirements for the individuals mandate The Secretary of HHS may not waive any law that is not within the jurisdiction of HHS (such as ERISA). The state will receive funds for implementing the waiver equal to any subsidies or tax credits for which residents would otherwise receive if the state had not received a waiver. State waiver plans must provide coverage that is at least as comprehensive as coverage offered through Exchanges, must cover at least as many state residents as this title would cover and may not increase the federal deficit. Waivers are good for 5 years and may be renewed unless the Secretary disapproves a request for renewal within 90 day of receipt. The Secretary must coordinate and consolidate this waiver application process and	**3/23/2010** **But any approved waivers will not be effective until 2017**	**OIC ?;** **MPA Support (Roger Gantz)**	**OIC?;** **MPA Support (Dia Tornatore)**	**A, T**			

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	the waiver processes for Medicare, Medicaid, CHIP, and any other federal health care law. ***Possible Action Needed & Status (date)*** ▪ Determine if and how this applies to Medicaid/low-income populations. It appears to be specific to requirements for the Exchange and qualified health benefits plans. ▪ HHS rules promulgated by 9/23/2010.							
	H. MEDICARE							
	I-78. FIVE-YEAR PERIOD FOR [DUAL ELIGIBLE] DEMONSTRATION PROJECTS [§ 2601 OF PPACA] Clarifies that the Medicaid demonstration waiver authority for coordinating care for dual eligibles may be as long as five years. ***Possible Action Needed & Status (date)*** ▪ None.	**3/23/2010**	**MaryAnne Lindeblad**	**Becky McAninch-Dake**	**C**			
✓	**I-79. FEDERAL COVERAGE AND PAYMENT COORDINATION FOR DUAL ELIGIBLE BENEFICIARIES [§ 2602 OF PPACA]** Requires HHS to establish a Federal Coordinated Health Care Office (CHCO) to help coordinate Medicare and Medicaid services for dual eligible beneficiaries and to improve coordination with States. ***Possible Action Needed & Status (date)*** ▪ ???	**3/1/2010**	**MaryAnne Lindeblad**	**Becky McAninch-Dake**	**T**			
✓	**I-80. GRANTS: MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM [§ 3129 OF PPACA]** Extends through September 30, 2011, the Medicare Rural Hospital Flexibility Program (a grant program administered by the Health Resources and Services Administration) and makes grant funding available to assist small rural hospitals to participate in delivery-system reforms (e.g., value-based purchasing, payment bundling) made by the Act. ***Possible Action Needed & Status (date)*** ▪ Coordinate with DOH and WSHA as needed.	**1/1/2010**	**DOH; MPA Support (Thuy Hua-Ly)**	**DOH; MPA Support (Carolyn Adams)**	**O**			

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	I. BASIC HEALTH OPTION							
✓	**I-81. BASIC HEALTH OPTION [§ 1331 OF PPACA]** A State, a group of States in a regional compact, or a State in coordination with other States, can offer one or more standard health plans that include the essential health benefits. The premium can be no more than if the individual had enrolled in a silver plan through the Exchange. HHS must certify the Basic Health (BH) Option and states are encouraged to offer more than one standard health plan. The plans must have a medical loss ratio of at least 85%. The BH Option can only offer individual plans and individuals must have family income between 133%—200% FPL. Individuals must be citizens or lawfully present in the US, cannot be eligible for Medicaid under Title XIX of the Social Security Act, must not be 65 or older, and cannot obtain service from the Exchange. Subsidies can equal 95% of the premium tax credits that would have been received under the Exchange. Subsidies can be used to offset the expense of premiums and cost-sharing. ***Possible Action Needed & Status (date)*** ▪ Include in planning for Exchange and monitor for any regulations or applications. ▪ Determine value of applying to HHS for this option. ▪ Prepare application.	**1/1/2014**	**Low-Income Workgroup (Roger Gantz); HCA (Preston Cody)**	**Low-Income Workgroup (Jenny Hamilton)**	**P**			
	J. AMERICAN INDIAN/ALASKAN NATIVE (AI/AN) POPULATION							
	1. SELECTED AI/AN- AND MEDICAID- RELATED PPACA PROVISIONS							
	I-82. INDIVIDUAL MANDATE NOT APPLICABLE TO MEMBERS OF INDIAN TRIBES [§§ 1411(b)(5), 1501, AND 1311(d)(4)(H) OF PPACA, AND 5000A(e)(3)] OF IRC] Applicants must provide information to be prescribed by the HHS Secretary if seeking exemption certification from any requirement for Exchange enrollment or penalty for non-enrollment based on Indian status. The Exchange must grant this certification.	**1/1/2014** **? (Unclear)**	**Roger Gantz/ Richard Onizuka in partnership with AIHC**	**Deb Sosa/ Jan Olmstead**	**P**			

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	Possible Action Needed & Status (date) ▪ Coordinate with transitional bridge waiver milestone in Basic Health – 2012 ability to verify tribal membership.							
	I-83. COST SHARING PROHIBITION FOR INDIANS AT OR BELOW 300% FPL [§§ 1402(D) AND 2901(A) OF PPACA] Plans may not impose any cost-sharing on Indians under 300% FPL or on any Indians receiving services from Indian health providers. HHS Secretary will pay that plan the amount necessary to reflect the increase in actuarial values of the plan as a result. ***Possible Action Needed & Status (date)*** ▪ Coordinate with transitional bridge waiver milestone in Basic Health – 2012 ability to verify tribal membership.	**1/1/2014** **? (Unclear)**	**Roger Gantz/ Richard Onizuka in partnership with AIHC**	**Deb Sosa/ Jan Olmstead**	**P**			
	I-84. INDIANS ALLOWED TO ENROLL IN EXCHANGE PLANS ON A MONTHLY BASIS [§ 1311(c)(6)(D) AND 1501(b) OF PPACA/5000A(e)(3) OF IRC] Members of Indian tribes may enroll in the Exchange for any month in which s/he is a member of a tribe. ***Possible Action Needed & Status (date)*** ▪ Coordinate with transitional bridge waiver milestone in Basic Health – 2012 ability to verify tribal membership.	**1/1/2014** **? (Unclear)**	**Roger Gantz/ Richard Onizuka in partnership with AIHC**	**Deb Sosa/ Jan Olmstead**	**P**			
	I-85. IHS AND INDIAN, TRIBAL, AND URBAN INDIAN FACILITIES MAY SERVE AS "EXPRESS LANE" AGENCIES TO DETERMINE MEDICAID/CHIP ELIGIBILITY [§2901(c)] Essentially creates presumptive eligibility for Medicaid or CHIP for Indians seeking services from Indian providers. ***Possible Action Needed & Status (date)*** ▪ **???**	**1/1/2014** **? (Unclear)**	**Roger Gantz/ Richard Onizuka in partnership with AIHC**	**Deb Sosa/ Jan Olmstead**	**P**			
	I-86. PAYER OF LAST RESORT [§ 2901(b) OF PPACA] Health programs operated by IHS, Indian tribes, tribal organizations, and urban Indian organizations are payer of last resort for services provided in those settings to individuals eligible through such programs.	**1/1/2014** **? (Unclear)**	**Roger Gantz/ Richard Onizuka in partnership with AIHC**	**Deb Sosa/ Jan Olmstead**	**P**			

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	Possible Action Needed & Status (date) ▪ No action. Drafted regulations for current policy.							
	I-87. EARLY CHILDHOOD HOME VISITATION PROGRAM GRANTS FOR TRIBES [§ 2951/511(h)(2)(A) OF PPACA] Approximately $90 million will be awarded this summer, to fund a new grant program for eligible States and territories that provides for evidence-based home visiting programs for children and families in at-risk communities. Additional funding will also be available to Tribes. Needs assessment and establishment of quantifiable 3- and 5- year benchmarks are required. One application per State, from Governor. ***Possible Action Needed & Status (date)*** ▪ Monitor. ▪ Lead agency must be designated, initial submission for grant dollars is July 9, 2010. ▪ Collaborate with DOH, CA, DEL, ESA, and Tribes as necessary.	**10/1/2009 (FFY 2010); initial submission is due by 7/9/2010**	**Roger Gantz/ Richard Onizuka in partnership with AIHC**	**Deb Sosa/ Jan Olmstead**	**T**			
	I-88. AHRQ QUALITY IMPROVEMENT TECHNICAL ASSISTANCE GRANTS AVAILABLE TO IHS PROGRAMS [§ 3501/934(b)(1)(A) OF PPACA] Grants funded under this section will identify, develop, evaluate, disseminate, and provide training in innovative methodologies and strategies for quality improvement practices in the delivery of health care services. Amends PHSA to make IHS programs eligible to receive a grant. A 1-to-5 match is required. Funding for AHRQ quality improvement/health care delivery system research is $20M for FFY 2010 to 2014. ***Possible Action Needed & Status (date)*** ▪ Consult with tribes as to level of interest.	**10/1/2009 (FFY 2010) – 9/30/2014 (FFY 2014)**	**Roger Gantz/ Richard Onizuka in partnership with AIHC**	**Deb Sosa/ Jan Olmstead**	**T**			
✓	**I-89. TRIBES ELIGIBLE FOR GRANTS TO ESTABLISH COMMUNITY HEALTH TEAMS TO SUPPORT THE PATIENT-CENTERED MEDICAL HOME [§ 3502(b)(1)(B) OF PPACA]** Requires, among other things, that the health teams established under these grants shall appropriately use HIT. ***Possible Action Needed & Status (date)***	**3/23/2010 ? (Unclear)**	**Roger Gantz/ Richard Onizuka in partnership with AIHC**	**Deb Sosa/ Jan Olmstead**	**T**			

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	▪ Consult with tribes as to level of interest. Does the State need to provide TA?							
	I-90. COOPERATIVE AGREEMENTS WITH TRIBES TO DEVELOP ORAL HEALTH INFRASTRUCTURE [§ 4102(c) OF PPACA] Requires HHS Secretary to enter into cooperative agreements with, among other entities, Indian tribes or tribal organizations to establish oral health leadership and program guidance, oral health data collection and interpretation, (including determinants of poor oral health among vulnerable populations), a multidimensional delivery system for oral health, and to implement science-based programs (including dental sealants and community water fluoridation) to improve oral health. Appropriations authorized for FFY 2010 through FFY 2014. ***Possible Action Needed & Status (date)*** ▪ Monitor regulations.	**3/23/2012** **(no later than)**	**Roger Gantz/ Richard Onizuka in partnership with AIHC**	**Deb Sosa/ Jan Olmstead**	**T**			
	I-91. STATES MAY RECEIVE GRANTS TO PROVIDE INCENTIVES TO MEDICAID CLIENTS FOR PARTICIPATING IN CHRONIC DISEASE PREVENTION PROGRAMS, WHICH MAY BE ADMINISTERED BY TRIBES [§ 4108(a)(3)(D) OF PPACA] Gives States flexibility to enter into arrangements with, among other entities, Indian tribes to develop incentive programs for smoking cessation, weight reduction, cholesterol lowering, blood pressure lowering, and diabetes avoidance/management. ***Possible Action Needed & Status (date)*** ▪ Consult with tribes as to level of interest. Does the State need to provide TA?	**1/1/2011** **(No later than)**	**Roger Gantz/ Richard Onizuka in partnership with AIHC**	**Deb Sosa/ Jan Olmstead**	**T**			
	I-92. PUBLIC HEALTH AND ALLIED HEALTH WORKFORCE RECRUITMENT AND RETENTION PROGRAMS FOR SERVICE AT PUBLIC HEALTH AGENCIES [§§ 5204/776 AND 5205 OF PPACA] Offers loan repayment to public health students and workers in exchange for working at least 3 years at a federal, state, local, or tribal public health agency. $195M appropriated for FY 2010, and necessary sums for FFY 2011 through 2015.	**10/1/2009** **(FFY 2010) – 9/30/2015 (FFY 2015)**	**Roger Gantz/ Richard Onizuka in partnership with AIHC**	**Deb Sosa/ Jan Olmstead**	**O, T**			

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	Also offers loan repayment for allied health professionals employed at public health agencies or HPSAs, MUAs, or for MUPs. ***Possible Action Needed & Status (date)*** ▪ Support DOH as needed.							
	I-93. ALTERNATIVE DENTAL HEALTH CARE PROVIDERS DEMONSTRATION PROJECTS IN RURAL, TRIBAL, AND UNDERSERVED COMMUNITIES [§ 5304/340G-1 OF PPACA] Secretary may award grants to establish training programs for alternative dental health care providers to increase access to dental health care services in rural, tribal, and underserved communities. ***Possible Action Needed & Status (date)*** ▪ Monitor regulations.	**3/23/2012 (no later than) – 3/23/2017 (no later than)**	**Roger Gantz/ Richard Onizuka in partnership with AIHC**	**Deb Sosa/ Jan Olmstead**	**T**			
	I-94. IHS MUST REPORT CLAIMS AND PAYMENT DATA TO THE INTEGRATED DATA REPOSITORY AS PART OF THE MEDICARE AND MEDICAID PROGRAM INTEGRITY PROGRAM [§ 6402(a)/1128J OF PPACA] See section I.D (Program Integrity) above for more detail. ***Possible Action Needed & Status (date)*** ▪ Monitor and review for integration into tribal HIT issues.	**3/23/2010? (Unclear)**	**Roger Gantz/ Richard Onizuka in partnership with AIHC**	**Deb Sosa/ Jan Olmstead**	**T**			
	I-95. CENTER FOR MEDICARE & MEDICAID INNOVATION [§10306/3021(a)(5)(B)(XIX) OF PPACA] Utilize telehealth services in IHS facilities to treat behavioral health issues and stroke, and to improve capacity of non-medical and non-specialized medical providers to render care for patients with chronic complex conditions. ***Possible Action Needed & Status (date)*** ▪ Review rules, workgroup with tribal representatives.	**1/1/2010 for establishment of the CMI**	**Roger Gantz/ Richard Onizuka in partnership with AIHC**	**Deb Sosa/ Jan Olmstead**	**T**			
	I-96. HEALTH BENEFITS PROVIDED BY INDIAN TRIBAL GOVERNMENT EXCLUDED FROM GROSS INCOME CALCULATIONS [§ 9021 OF PPACA/§139D(b) OF IRC] Provides an exclusion from gross income for the value of specified Indian tribal health benefits. Amends the IRC to include as a general rule that gross income does	**3/23/2010**	**Roger Gantz/ Richard Onizuka in partnership with AIHC**	**Deb Sosa/ Jan Olmstead**	**T**			

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	not include the value of any qualified Indian health care benefit. Contains a double benefit exclusion, which means this rule will not apply to the amount of any qualified Indian health care benefit which is not includible in gross income of the beneficiary of such benefit under any other provision of the tax code, or to the amount of any such benefit for which a deduction is allowed to that beneficiary. This provision is important in that the new language closes an important "gap" in the tax code and thereby honors tribal government sovereignty and treaty rights. ***Possible Action Needed & Status (date)*** ▪ Monitor for impact on eligibility/training issues for ESA and Exchange.							
	I-97. RE-AUTHORIZED THE INDIAN HEALTH CARE IMPROVEMENT ACT [§ 10221 OF PPACA] See below for applicable details.	**3/23/2010**						
	2. INDIAN HEALTH CARE IMPROVEMENT ACT (TITLE X, SUBTITLE B, PART III, § 10221 OF PPACA; SEE ALSO S.1790 AND							
	I-98. CREDITING OF REIMBURSEMENTS [§ 126/207 OF S.1790/IHCIA (42 USC § 1621f)] IHS may not offset or limit any amount obligated to any service unit, tribe, tribal organization or urban Indian organization because of receipt of reimbursements under Medicare, Medicaid or SCHIP and other provisions of law. ***Possible Action Needed & Status (date)*** ▪ None.	**3/23/2010** **? (Unclear)**	**Roger Gantz/ Richard Onizuka in partnership with AIHC**	**Deb Sosa/ Jan Olmstead**	**T**			
	I-99. LICENSING [§ 134/221 OF IHCIA] New provision exempts a licensed health care professional who is employed by a tribally operated health program from state licensing requirements if the professional is licensed in any state, as is the case with IHS health care professionals. ***Possible Action Needed & Status (date)*** ▪ Incorporate into policies for Provider Enrollment.	**3/23/2010** **? (Unclear)**	**Roger Gantz/ Richard Onizuka in partnership with AIHC**	**Deb Sosa/ Jan Olmstead**	**P**			
	I-100. LICENSING REQUIREMENT FOR MENTAL HEALTH CARE WORKERS [§ 706 OF IHCIA]	**3/23/2010**	**Roger Gantz/ Richard Onizuka**	**Deb Sosa/ Jan Olmstead**	**P**			

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	NHR PROVISION	EFFECTIVE DATE	LEAD SPONSOR(S)	LEAD MANAGER(S)	TYPE	*LEGISLATION NEEDED (date)	*FISCAL IMPACT (date)	*CRITICALITY (high, med, low)
	Prescribes mandatory licensing requirements for mental health workers and establishes protocols for oversight of mental health trainees. ***Possible Action Needed & Status (date)*** ▪ Monitor for possible integration into Medicaid program.	**? (Unclear)**	**in partnership with AIHC**					
	I-101. GAO REPORTS [§ 199/830 OF IHCIA] The Comptroller General (CG) of the United States is directed to conduct a study, and evaluate the effectiveness of coordination of health care services provided to Indians through Medicare, Medicaid, or SCHIP, by the Service or using funds provided by State or local governments or Indian tribes. ***Possible Action Needed & Status (date)*** ▪ None.	**09/20/2011** **CG to submit no more than 18 months after IHCIA enactment**	**Roger Gantz/ Richard Onizuka in partnership with AIHC**	**Deb Sosa/ Jan Olmstead**	**T**			
	K. COMMUNITY LIVING ASSISTANCE AND SUPPORTS (CLASS) ACT (TITLE VIII OF PPACA)							
	I-102. CLASS ENROLLMENT [§ 8002(a)(1)/§ 3202(1)-(2) AND § 3204] Working adults will be able to make voluntary premium contributions either through payroll deductions through their employer or directly. All working adults will be automatically enrolled in the program, unless they choose to opt-out. ***Possible Action Needed & Status (date)*** ▪ Determine if there is an MPA Human Resources impact.	**1/1/2011** **benefit defined by 10/2012 with enrollment thereafter**	**HCA/PEBB; MPA Support (Gail Douglas)**	**HCA/PEBB; MPA Support (Myla Hite)**	**A, T**			
	I-103. CLASS ELIGIBILITY [§ 8002(a)(1)/§ 3202(6)] Adults with multiple functional limitations, or cognitive impairments, will be eligible for benefits if they have paid monthly premiums for at least five years and have been employed during three of those five years. ***Possible Action Needed & Status (date)*** ▪ None?	**1/1/2011** **benefit defined by 10/2012 with enrollment thereafter**	**HCA/PEBB**		**A**			
	I-104. CLASS BENEFITS [§ 8002(a)(1)/§ 3203(a)(1)(D) AND § 3205] Adults who meet eligibility criteria will receive a cash benefit that can be used to	**1/1/2011** **benefit defined**	**HCA/PEBB; MPA Support (Gail**	**HCA; MPA Support (Myla**	**A, T**			

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	NHR PROVISION	EFFECTIVE DATE	LEAD SPONSOR(S)	LEAD MANAGER(S)	TYPE	*LEGISLATION NEEDED (date)	*FISCAL IMPACT (date)	*CRITICALITY (high, med, low)
	purchase non-medical services and supports necessary to maintain community residence; payments for institutional care are permitted. The amount of the cash benefit is based on the degree of impairment or disability, averaging no less than $50 per day. ***Possible Action Needed & Status (date)*** ▪ Determine if there is an MPA Human Resources or Fiscal impact.	**by 10/2012 with enrollment thereafter**	**Douglas)**	**Hite)**				
	I-105. CLASS FINANCING [§ 8002(a)(1)/§ 3203(a)(1)(A) AND (b), AND § 3210] CLASS is financed by voluntary premium contributions paid by working adults, either through payroll deductions or direct contributions. Nominal premium for poorest individuals and full-time students. Treated the same for tax purposes as a qualified long-term care (LTC) insurance contract for qualified LTC services. ***Possible Action Needed & Status (date)*** ▪ Determine if there is an MPA Human Resources impact.	**1/1/2011** **benefit defined by 10/2012 with enrollment thereafter**	**HCA/PEBB; MPA Support (Gail Douglas)**	**HCA; MPA Support (Myla Hite)**	**A, T**			
	I-106. CLASS INTERACTION WITH MEDICAID [§ 8002(a)(1)/§ 3205(c)(1)(D] CLASS will generally be the primary payer for individuals who are also eligible for Medicaid; won't impact Medicaid eligibility, but if eligible for both programs then the CLASS benefits will be used to offset the costs of Medicaid LTC. ***Possible Action Needed & Status (date)*** ▪ Coordinate with ADSA as necessary and determine if there is a COB issue.	**1/1/2011** **benefit defined by 10/2012 with enrollment thereafter**	**ADSA; MPA Support (Thuy Hua-Ly)**	**ADSA; MPA Support (Andy Renggli)**	**A, T**			
	L. OTHER GRANTS [*SEE FFIS SPECIAL ANALYSIS 10-02 (5/24/2010) FOR A FULL INVENTORY OF FUNDING OPPORTUNITIES*]							
✓	**I-107. GRANTS FOR IMMUNIZATION COVERAGE [§ 4204]** Requires HHS to conduct a demonstration program of grants to States to improve immunization coverage of children, adolescents and adults, subject to appropriations. ***Possible Action Needed & Status (date)*** ▪ Assess level of interest and collaborate with DOH as needed.	**3/23/2010**	**DOH; MPA Support (MaryAnne Lindeblad)**	**DOH; MPA Support (Margaret Wilson)**	**O, T**			

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✓	**I-108. GRANTS FOR HEALTH INSURANCE CONSUMER ASSISTANCE [§ 1002/2793]** Applies to all health insurance coverage with respect to federal health insurance requirements and state law. Grants will be awarded to states for establishing an independent office of consumer assistance/ombudsman. $30M is appropriated for the first fiscal year. The office will receive, respond, and report upon consumer complaints. ***Possible Action Needed & Status (date)*** ▪ Coordinate (especially if the OIC submits and receives a grant on behalf of Washington State) and comply as needed.	**9/20/2010** **(Depends on grant but will begin no sooner than this date)**	**OIC; ADSA, MPA Support (Manning Pellanda)**	**OIC; ADSA, MPA Support (Diane Getchman)**	**O, T**			
	I-109. MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITATION GRANT PROGRAM [§ 2951 OF PPACA] Approximately $90 million will be awarded this summer, to fund a new grant program for eligible States and territories that provides for evidence-based home visiting programs for children and families in at-risk communities. Additional funding will also be available to Tribes. One application per State, from Governor. ***Possible Action Needed & Status (date)*** ▪ Lead agency must be designated (DOH?), initial submission for grant dollars is July 9, 2010. ▪ Collaborate with DOH, CA, DEL, ESA, and Tribes as necessary	**10/1/2009** **(FFY 2010); initial submission is due by 7/9/2010**	**DOH; MPA Support (MaryAnne Lindeblad)**	**DOH; MPA Support (Todd Slettvet)**	**O, T**			
✓	**I-110. COMMUNITY PREVENTION GRANTS [§ 4202]** Requires HHS to create a program of grants to State or local health departments or Indian tribes for five-year pilot programs to provide community prevention interventions, screenings, and clinical referrals for individuals who are between 55 and 64 years of age. HHS also is required to conduct an evaluation of community-based prevention and wellness programs, and, based on findings, develop a plan for promoting healthy lifestyles and chronic disease self-management for Medicare beneficiaries. To fund this evaluation, HHS is required to transfer to CMS $50 million in total from the Medicare Part A and Part B Trust Funds, in whatever proportion HHS	**3/23/2010**	**DOH; MPA Support (MaryAnne Lindeblad)**	**DOH; MPA Support (Todd Slettvet)**	**O, T**			

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	determines. ***Possible Action Needed & Status (date)*** ▪ Support Tribes in any grant applications they may put forth.							
	I-111. GRANTS FOR STATES OR TRIBES TO ESTABLISH MEDICAL HOMES [§ 3502 AND § 3511] The medical homes will focus upon integrated health teams. These teams will provide support to primary care providers who will receive capitated payments and will include support for patient-centered medical homes. State or state-designated entity, or tribe, can apply for grants. Grant opportunities likely to dovetail with medical home efforts underway in Washington State. ***Possible Action Needed & Status (date)*** ▪ Support Tribes in any grant applications they may put forth.	**3/23/2010**	**Tribes; MPA Support (Roger Gantz/MaryAnne Lindeblad)**	**Tribes; MPA Support (Deb Sosa/Shirley Munkberg)**	**O, T**			
	I-111A. GRANTS FOR MEDICAL HOMES THROUGH THE PRIMARY CARE EXTENSION PROGRAM (PCEP) [§ 5405 OF ACA AND S 10501(F)] Authorizes grants to help primary care providers bring the medical home approach into their practices. The patient-centered medical home intends to provide comprehensive patient care in a more integrated, coordinated, and evidence-driven manner. To assist providers in operating medical homes, the ACA provides grants to states to set up State Hubs, which in turn will award grants to local Primary Care Extension Agencies, who will coordinate directly with providers. Makes available to states two types of grants: (1) a two-year grant for states to plan State Hubs, and (2) a six-year grant to fund the implementation of State Hubs in accordance with a fully developed plan. Authorizes Congress to appropriate $120M each for 2011 and 2012. ***Possible Action Needed & Status (date)*** ▪ Await HHS issuance of application for the planning and implementation grants (likely won't do until Congress appropriates the funds). ▪ Health A Team to determine lead agency.	**3/23/2010** **But no mandated date by which HHS must make the grants**	**?; MPA support (MaryAnne Lindeblad)**	**?; MPA Support (Shirley Munkberg)**	**?**			
	M. HEALTH INSURANCE REFORM							

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	NHR Provision	Effective Date	Lead Sponsor(s)	Lead Manager(s)	Type	*Legislation needed (date)	*Fiscal Impact (date)	*Criticality (high, med, low)
✓	**I-112. a. Guaranteed Issuance and Renewability [§§ 1201 of PPACA/2702 and 2703 of PHSA]** **b. No Lifetime Limits on Coverage [§§ 1001 PPACA/2711 PHSA and 2301 of HCERA]** **c. No "Unreasonable" Annual Limits on Overall Plan Coverage [§§ 1001 PPACA/2711 PHSA and 2301 of HCERA]** **d. No Canceling Enrollee Coverage /No Rescissions [§§ 1201 of PPACA/2712 of PSHA and 2301 of HCERA]** **e. Temporary Federal High-Risk Pool [§ 1101 of PPACA]** **f. No Excessive Waiting Periods [§§ 1201 of PPACA/2708 of PSHA]** **g. No Pre-Existing Condition Clauses for Children [§§ 1201 PPACA/2704, 2705 PHSA]** **h. Coverage Available To Child Dependents Until They Turn 26 [§§ 1001 of PPACA/2714 of PHSA and 2301(a) and (b) of HCERA/2714(a) of PHSA]** See HCA Project Planning/Sponsor Manager document for more details. ***Possible Action Needed & Status (date)*** ▪ Determine if prohibitions on lifetime/annual limits apply to limits Medicaid/ HO plans may have on certain benefits (e.g., physical therapy for adults?).	**e. 1/1/2014** **f. Plan years (PY) beginning on after 9/20/10** **g. PY on or after 9/20/10** **h. PY on or after 9/20/10** **i. 6/21/2010** **j. 1/1/2014** **k. 9/20/2010** **l. PY on or after 9/20/10**	**OIC; MPA Support (MaryAnne Lindeblad)**	**OIC; MPA Support (Gail Kreiger/ Michael Paulson)**	**O, A**			
✓	**I-113. No Cost-Sharing for "A" or "B" rated Evidence-Based Preventive Services, Immunizations, and Preventive Care/Screenings for Infants, Children, Adolescents, and Women [§ 1001/2713]** Applies to new group health plans or health insurance issuer offering new group or individual insurance coverage. Applies to all plans in 2018. Applies to preventive services rated A or B by the U.S. Preventive Services Task Force. ***Possible Action Needed & Status (date)*** ▪ Determine if applicable to MPA and HO plans; if so, ensure compliance.	**1/1/2011** **(Coverage begins for new plans); 2018 for existing plans**	**OIC; MPA Support (MaryAnne Lindeblad)**	**OIC; MPA Support (Gail Kreiger/ Michael Paulson)**	**O, A**			
✓	**I-114. Uniform Coverage Documents [§ 1001/2715]** Applies to group health plans or health insurance issuer offering group or individual insurance coverage. Within 12 months of enactment, HHS will develop standards – in consultation with NAIC – for describing benefits and coverage.	**1/1/2012** **Likely effective for coverage that starts 1/1/2012 or 1/1/2013**	**OIC; MPA Support (MaryAnne Lindeblad)**	**OIC; MPA Support (Gail Kreiger/ Michael Paulson)**	**O, T**			

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	Possible Action Needed & Status (date) ▪ Review 2010 HHS regulations and ensure that MPA and HO definitions and standards comply. ▪ If not, take action to comply within 24 months of enactment, which is 3/23/12.	**(depends on when regulations are adopted)**						
✓	**I-115. NEW APPEALS PROCESS FOR HEALTH INSURANCE PLAN DECISIONS [§ 1001/2719]** Applies to group health plans or health insurance issuer offering group or individual insurance coverage. The appeal processes used under Washington's Patients' Bill of Rights for private insurance plans and, if applicable, for HO health plans may be robust enough to satisfy the directives and regulations associated with this section. ***Possible Action Needed & Status (date)*** ▪ Review 2010 HHS regulations and, if applicable, confirm that HO plans are in compliance. ▪ If applicable and not in compliance, take action to comply.	**9/23/2010**	**OIC; MPA Support (MaryAnne Lindeblad)**	**OIC; MPA Support (Michael Paulson)**	**O, T**			
✓	**I-116. STANDARD INFORMATION ON AFFORDABLE COVERAGE OPTIONS [§ 1103]** HHS to establish standard information on coverage options provided through web. ***Possible Action Needed & Status (date)*** ▪ HHS to develop format by 5/23/2010. ▪ Per C&B memo 27, HHS will not be imposing any new reporting obligations on States to implement the Medicaid/CHIP portion of the Web portal. All of the data will be derived from sources internal to CMS. ▪ Health insurance issuers, possibly including Medicaid-contracted MCOs, may have to submit information to HHS for posting on the portal (45 CFR 159.120)	**7/1/2010** **(HHS will make portal live on or by this date)**	**MaryAnne Lindeblad**	**Michael Paulson**	**A, T**			
✓	**I-117. REPORTING HEALTH INSURANCE COVERAGE [§ 6055]** Health insurance issuers, group health plans, and governments providing coverage must annually report information about an individual's coverage to the IRS in a form	**Taxable years and coverage beginning**	**OIC; MPA Support (MaryAnne**	**OIC; MPA Support (Gail Kreiger/ Michael Paulson)**	**O, T**			

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	and manner prescribed by HHS. The responsibility to report falls to the issuer of fully-insured HO plans and the exchange, and to the MPA for self-funded plans. Information to report includes an insured's name, address, primary insurance, premium, and subsidies. ***Possible Action Needed & Status (date)*** ▪ Monitor and respond, if necessary, to standards or regulations issued by HHS.	**1/1/2014.**	**Lindeblad)**					
II.	**EXCHANGE PROVISIONS IMPACTING LOW-INCOME POPULATIONS**							
✓	**II-1. QUALIFIED HEALTH PLANS AND ESSENTIAL HEALTH BENEFITS [§ 1301, 1302, AND 1303]** A qualified health plan offers the essential health benefits. A health insurance issuer must offer qualified health plans in at least the silver and gold levels of an exchange. CO-OP and multi-state plans are deemed to be qualified health plans. The term ''health plan'' means health insurance coverage and a group health plan. Except to the extent specifically provided by this title, the term ''health plan'' shall not include a "group health plan" or multiple employer welfare arrangements (MEWA) that are not subject to state insurance regulation. These usually take the form of self-funded employer-sponsored insurance or self-funded MEWAs. ***Possible Action Needed & Status (date)*** ▪ Determine if these new requirements are applicable to HO plans. ▪ Monitor, and respond if necessary, to the Secretary's submittal to Congress of actuarial certification of the guidelines on essential health benefits. ▪ Monitor, and respond if necessary, to HHS regulations on establishing levels.	**1/1/2014** **Coverage provided under qualified health plans no later than 1/1/2014**	**Exchange Workgroup (Richard Onizuka); MPA Support (Low-Income Workgroup (LI WG))**	**Exchange Workgroup (Michael Arnis); MPA Support (Low-Income Workgroup (LI WG))**	**O, T**			
✓	**II-2. EXCHANGES AND AFFORDABLE CHOICES [§ 1304, 1311, 1312, 1313, AND 1321]** Exchanges, including the option for a state-based Small Business Health Options Program (SHOP) Exchange, will offer small group and individual health plans no later than January 1, 2014 and only to citizens or people lawfully present in the US. A	**3/23/2011** **(grants issued before)**	**Exchange Workgroup (Richard Onizuka); MPA**	**Exchange Workgroup (Michael Arnis); MPA Support (LI**	**O, T**			

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	state can implement a small group market defined as 1-50 employees before January 1, 2016, at which time small group plans will be offered to employers with 1-100 employees. *The Exchange may screen individuals for Medicaid, CHIP, and other state or local program and—if eligible for any of those programs—enroll them.* States may require qualified health plans to offer benefits in addition to the essential health benefits. Those states will be required to "defray" the costs of those additional benefits. This could mean that state premium subsidies will be expected to fill-in for federal premium subsidies for the additional benefits. We should interpret a state's responsibility as follows: To ensure that *all* benefits of a qualified health plan can receive federal premium subsidies, a state's mandated benefits must align with the essential health benefits. As soon as practicable, HHS will issue regulations that set standards for exchanges. By January 1, 2014, states must adopt the HHS standards and have state laws or regulations in effect that HHS determines necessary to implement an exchange [§ 1321]. ***Possible Action Needed & Status (date)*** ▪ Collaborate with HCA as needed to establish a statewide plan for designing and developing an Exchange. States must consult with stakeholders relevant to carrying out the activities of an exchange [§ 1311]. Include coordination with insurance reforms such as merging individual and small group markets, and considering implementing a 1-100 employee small group market on 1/1/2014. ▪ Coordinate with HCA as needed to monitor and respond to HHS regulations – issued as soon as practicable -- that set standards for exchanges [§ 1321]. ▪ Coordinate with HCA as needed to monitor and respond to HHS establishment grants. ▪ Monitor and respond to HHS regulations on qualified health plans. ▪ Coordinate with HCA to develop streamlined standards and procedures	**1/1/2013 (CO-OP grants by)** **1/1/2014** **(State laws and regulations on exchanges in effect by)** **1/1/2014** **(Coverage provided under qualified health plans no later than).** **1/1/2015** **(Self-sustained operations)** **1/1/2015** **(Hospital contracting standards for qualified health plans effective)**	**Support (LI WG)**	**WG)**				

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	for determining eligibility for Exchange plans, Medicaid, or CHIP.							
	II-3. STREAMLINING PROCEDURES FOR ENROLLMENT THROUGH A HEALTH INSURANCE EXCHANGE AND MEDICAID, CHIP, AND OTHER HEALTH SUBSIDY PROGRAMS [§ 1413 OF PPACA] See Section 1.A.3 (Outreach and Enrollment Facilitation) above.	**1/1/2014**	**Exchange Workgroup; MPA Support (LI WG)**	**Exchange Workgroup; MPA Support (LI WG)**	**O, T**			
	II-4. ENROLLMENT SIMPLIFICATION AND COORDINATION WITH STATE HEALTH INSURANCE EXCHANGES [§ 2201 OF PPACA] See Section 1.A.3 (Outreach and Enrollment Facilitation) above.	**1/1/2014**	**Exchange Workgroup; MPA Support (LI WG)**	**Exchange Workgroup; MPA Support (LI WG)**	**O, T**			
III	**HIT PROVISIONS IMPACTING LOW-INCOME POPULATIONS**							
	III-1. ENROLLMENT SIMPLIFICATION AND COORDINATION WITH STATE HEALTH INSURANCE EXCHANGES [§ 2201 OF PPACA] See Section I.A.3 (Outreach and Enrollment Facilitation) above.	**1/1/2014**	**Manning Pellanda with support from ESA; Exchange Steering Workgroup**	**Mary Wood**	**P**			
✓	**III-2. INTERNET PORTAL TO AFFORDABLE COVERAGE OPTIONS [§1103(a)]** HHS to establish standard information on coverage options provided through web. ***Possible Action Needed & Status (date)*** ▪ HHS to develop format by May 23, 2010. ▪ Per C&B memo 27, HHS will not be imposing any new reporting obligations on States to implement the Medicaid/CHIP portion of the Web portal. All of the data will be derived from sources internal to CMS. ▪ Health insurance issuers, possibly including Medicaid-contracted MCOs, may have to submit information to HHS for posting on the portal (45 CFR 159.120)	**3/23/2010** **portal live on or by 7/1/2010**	**MaryAnne Lindeblad**	**Michael Paulson**	**A, T**			
✓	**III-3. ADMINISTRATIVE SIMPLIFICATION [§ 1104(b)(2)(B)(i)(4)(B) OF PPACA]** Amends HIPAA to tighten existing transaction standards in order to simplify financial	**1/1/2012**	**Rich Campbell**	**Karen DeLeon**	**P**			

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	and administrative transactions. In developing recommendations under this subsection, the review committee shall ensure coordination, as appropriate, with the standards that support the certified electronic health record technology approved by the Office of the National Coordinator for Health Information Technology. Health plans must certify compliance and face penalties when they do not. Requires Secretary rulemaking related to: **a.** Unique Health Plan Identifiers (interim rules by 10/1/2012; eff. 1/1/2014; cert. deadline 12/31/2013) **b.** Electronic funds transfer (interim rules by 1/1/2012; eff. 1/1/2014; cert. deadline 12/31/2013) **c.** Health claims attachments (interim rules by 1/1/2014; eff/ 1/1/2016; cert. deadline 12/31/2015) *Plans, including state Medicaid agencies and Medicaid managed care plans, will be assessed penalty fees (of $1 per "covered life" for each day of non-compliance) by 4/1/2014 if they don't comply with the operating rules by certifying by specified dates.* ***Possible Action Needed & Status (date)*** ▪ Review, evaluate, and implement necessary system changes.	**Various**						
	III-4. HIT ENROLLMENT STANDARDS & PROTOCOLS [§ 1561 OF PPACA] HHS Secretary must develop, within 180 days of PPACA's enactment, interoperable and secure standards and protocols that facilitate the electronic enrollment of individuals in Federal and State health and human services programs. In developing these standards, HHS must consult with the HIT Policy Committee and the HIT Standards Committee, two Federal advisory committees established by ARRA. HHS also must determine appropriate methods to facilitate enrollment in the programs, which must include providing individuals and authorized 3rd parties notification of eligibility and verification of eligibility required under the programs. HHS must notify States of the approved standards or protocols and may condition	**9/20/2010**	**Rich Campbell; Exchange Workgroup**	**TBD**	**P**			

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	receipt of federal funds for HIT investments on incorporation of them. HHS will award grants to develop new and adapt existing technology systems to implement the HIT standards and protocols. Eligible entities must be states, political subdivisions of States, or local governmental entities. ***Possible Action Needed & Status (date)*** ▪ Coordinate with HCA and determine if MPA should apply for the grant. ▪ Review, evaluate, and implement necessary system changes as applicable.							
	III-5. HIT REQUIREMENTS FOR STATE OPTION TO PROVIDE HEALTH HOMES FOR ENROLLEES WITH CHRONIC CONDITIONS [§ 2703(a)/(f)(2) OF PPACA] As part of the SPA related to the option, each State must include a proposal for use of HIT in providing health home services and improving service delivery and coordination. See Section I.E. (Medicaid Demonstration & Grant Funding) above for program details. ***Possible Action Needed & Status (date)*** ▪ Determine whether MPA will pursue this State Plan option and, if so, how to incorporate HIT.	**1/1/2011**	**Rich Campbell; MaryAnne Lindeblad**	**TBD; Shirley Munkberg**	**P**			
	III-6. GRANTS FOR QUALITY MEASUREMENT DEVELOPMENT [§3013/931(c)(2)(D) OF PPACA] In awarding grants, contracts, or intergovernmental agreements to eligible entities for the development of quality measures, the HHS secretary will give priority to measures that assess, among other things, the meaningful use of HIT. $75M is appropriated each FFY from 2010 through 2014. ***Possible Action Needed & Status (date)*** ▪ Await Secretary identification of gaps where no quality measures exist.	**10/1/2009** **(FFY 2010) – 9/30/2014 (FFY 2014)**	**Rich Campbell**	**TBD**	**P**			
	III-7. HIT REQUIREMENTS FOR ESTABLISHMENT OF CENTER FOR MEDICARE AND MEDICAID INNOVATION (CMI) WITHIN CMS [§3021 (a)/(b)(2)(B)(v) AND (C)(iv) OF PPACA] When selecting innovative payment and service delivery models to test, those considered will, for example, support care coordination before chronically ill	**1/1/2010** **for establishment of the CMI**	**Rich Campbell**	**TBD**	**P**			

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	individuals at high risk of hospitalization through an HIT-enabled provider network that includes care coordinators, a chronic disease registry, and home tele-health technology. Budget neutrality is not required. See section I.G (Miscellaneous Medicaid Provisions) above for program details. ***Possible Action Needed & Status (date)*** ▪ Determine, if there is interest, how MPA programs may serve as a model.							
	III-8. UNDERSTANDING HEALTH DISPARITIES, DATA COLLECTION AND ANALYSIS [§ 4302 OF PPACA] Any federally conducted or supported health care or public health program, activity or survey, must collect and report certain specified data, according to standards that will be established by the HHS Secretary. To address health care disparities in Medicaid and CHIP, there will be standardized collection requirements included in State Plans. ***Possible Action Needed & Status (date)*** ▪ Amend State Plan. ▪ Review and implement specified data collection, analysis, management, and reporting standards.	**3/23/2012** **(No later than 2 years after enactment)**	**Rich Campbell**	**TBD**	**P**			
	III-9. DEVELOPMENT OF STANDARDS FOR FINANCIAL AND ADMINISTRATIVE TRANSACTIONS [§ 10109(b)(1) OF PPACA] HHS Secretary will seek input on whether the application process, including the use of a uniform application form, for enrollment of health care providers by health plans could be made electronic and standardized. ***Possible Action Needed & Status (date)*** ▪ Monitor and provide input as necessary.	**1/1/2012** **(Not later than)**	**Rich Campbell**	**TBD**	**P**			
IV	**WORKFORCE PROVISIONS IMPACTING LOW-INCOME POPULATIONS**							
✓	**IV-1. STATE HEALTH CARE WORKFORCE DEVELOPMENT [§ 5102]** Establishes a State health care workforce development grants program, subject to	**03/23/2010** **application**	**Provider Workforce**	**Provider Workforce**	**O, T**			

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	appropriations, to help State partnerships implement comprehensive health care workforce development strategies at the State and local level. ~30 awards. ***Possible Action Needed & Status (date)*** ▪ Collaborate with DOH as needed.	**deadline 7/19/2010**	**Workgroup; MPA Support (Jeff Thompson)**	**Workgroup; MPA Support (ask Jeff)**				
	IV-2. PAYMENTS FOR PRIMARY CARE PROVIDERS [§ 1202 OF HCERA] See Section I.C. (Medicaid Financing) above	**1/1/2013** **for services provided in CY 2013**	**Thuy Hua-Ly; MaryAnne Lindeblad**	**Scott Palafox; Michael Paulson**	**P**			
	IV-3. PEDIATRIC ACCOUNTABLE CARE ORGANIZATION DEMONSTRATION PROJECT [§ 2706 OF PPACA] See Section I.E. (Medicaid Demonstration & Grant Funding) above	**1/1/2012 – 12/31/2106**	**MaryAnne Lindeblad**	**Barb Lantz**	**A**			
	IV-4. HEALTH HOMES FOR ENROLLEES WITH CHRONIC CONDITIONS: PLANNING GRANTS [§ 2703 OF PPACA] See Section I.E. (Medicaid Demonstration & Grant Funding) above.	**1/1/2011**	**MaryAnne Lindeblad**	**Shirley Munkberg**				
✓	**IV-5. COMMUNITY HEALTH CENTERS [§ 2303 OF HCERA]** *Additional* federal funding for CHCs under section 330 of the PHSA: $1.0B in federal fiscal year 2011 (up from $700M in PPACA § 10503(a)(1)(A)) to $3.6B in FFY 2015 (up from $2.9B in PPACA § 10503(a)(1)(E)). The language is broad enough in § 5601 of the PPACA that it may allow FQHCs to be eligible for the increase in funding for Sec 254 of the PHSA (CHC Program). ***Possible Action Needed & Status (date)*** ▪ Examine what impact, if any, this additional funding may have on FQHC activity.	**10/1/10** **(Could be as soon as)**	**Thuy Hua-Ly**	**Scott Palafox**	**?**			
	IV-6. PUBLIC HEALTH AND ALLIED HEALTH WORKFORCE RECRUITMENT AND RETENTION PROGRAMS FOR SERVICE AT PUBLIC HEALTH AGENCIES [§§ 5204/776 AND 5205 OF PPACA] See section I.J.1 (Selected AI/AN- And Medicaid- Related PPACA Provisions) above.	**10/1/2009** **(FFY 2010) – 9/30/2015 (FFY**	**Provider Workforce Workgroup**	**Provider Workforce Workgroup**	**O, T**			

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		2015)						
✓	**IV-7. NURSE-MANAGED HEALTH CLINICS GRANT PROGRAM [§ 5208]** Establishes a grant program, subject to appropriations, to fund nurse-managed health clinics. ***Possible Action Needed & Status (date)*** ▪ Collaborate with DOH and Provider Workforce Workgroup as needed.	10/1/2009 (FFY 2010) – 9/30/2014 (FFY 2014)	Provider Workforce Workgroup; MPA Support (Jeff Thompson)	Provider Workforce Workgroup; MPA Support (ask Jeff)	O, T			
	IV-8. PROVIDER SCREENING & OTHER ENROLLMENT REQUIREMENTS [§§ 6401 AND 10603 OF PPACA] See Section I.D (Program Integrity) above	3/23/2011 (new); 3/23/2012	Manning Pellanda	Diane Getchman	A, T			
	IV-9. ALTERNATIVE DENTAL HEALTH CARE PROVIDERS DEMONSTRATION PROJECTS IN RURAL, TRIBAL, AND UNDERSERVED COMMUNITIES [§ 5304/340G-1 OF PPACA] See section I.J.1 (Selected AI/AN- And Medicaid- Related PPACA Provisions) above.	3/23/2012 (no later than) – 3/23/2017 (no later than)	MaryAnne Lindeblad	Margaret Wilson	T			
	IV-10. OTHER PAYMENT REFORM PILOT PROGRAMS See Section I.E. (Medicaid Demonstration & Grant Funding) above	Various	MaryAnne Lindeblad	Shirley Munkberg				

More detailed information about these provisions may be found, for example, in the following hyper-linked documents:

- H.R. 3590 (PPACA)
- H.R. 4872 (HCERA)
- S. 1790 (IHCIA)
- Covington & Burling Advisory PPACA Memoranda #1-50
- NASMD "*Summary of Provisions Affecting Medicaid and SCHIP in the PPACA as Amended by the HCERA of 2010*" (4/23/2010)
- Congressional Research Service "*Medicaid and the State Children's Health Insurance Program (CHIP) Provisions in PPACA*" (4/28/2010)
- Kaiser Family Foundation "*Medicaid and Children's Health Insurance Program Provisions in the New Health Reform Law*" (4/7/2010)
- Kaiser Family Foundation "*Medicaid and CHIP Health Reform Implementation Timeline*" (4/12/2010)
- Kaiser Family Foundation "*Summary of New Health Reform Law*" (4/08/2010)

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- Kaiser Family Foundation "*Health Reform Implementation Timeline*" (4/27/2010)
- NIHB "*Preliminary Summary of the Patient Protection and Affordable Care Act and the Indian Health Care Improvement Act*" (3/26/2010)
- FFIS "*Special Analysis 10-02, Health Care Reform: Inventory of Funding Opportunities*" (5/24/2010)
- Social Security Act Title XIX
- Social Security Act Title XXI

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